

Wednesday, 20 November 2024

1
2 (10.00 am)
3 **LADY HALLETT:** Ms Carey.
4 **MS CAREY:** Good morning. My Lady, the first witness today
5 is Mr Vaughan Gething. He is appearing via video link
6 and he will affirm.
7 **LADY HALLETT:** Thank you.
8 **MR VAUGHAN GETHING (affirmed)**
9 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3**
10 **LADY HALLETT:** Mr Gething, thank you for coming back to help
11 us again.
12 **THE WITNESS:** Bore da, my Lady.
13 **MS CAREY:** Mr Gething, good morning. We have a number of
14 topics to cover this morning. I hope you have in front
15 you a copy of your statement, INQ000474252, to which we
16 will be going at various points in the evidence.
17 May I start with some background. I think you are
18 a lawyer by background. First became a member of the
19 Senedd in May 2011, and five years later, in May 2016,
20 became the Cabinet Secretary for Health, Well-being and
21 Sport, which in due course became the Minister for
22 Health and Social Services; is that correct?
23 **A.** That is correct.
24 **Q.** And you remained the minister I think until 13 May 2021?
25 **A.** That's correct.

1

1 help us, please, with some examples of the things that
2 they were telling you.
3 **A.** So there were a number of things, both about how they'd
4 had to re-organise services to ensure the service didn't
5 become overwhelmed. You'll recall I made a statement on
6 13 March, so some of it was about what had happened
7 since then. A lot of it was about the current
8 situation. So that's not in terms of operationally what
9 they were doing but a large part of their concern was
10 about staff, staff welfare and well-being and what was
11 coming next. Because we still didn't know a great deal
12 at that time so people were living with fear, both in
13 the wider public and indeed in our health and social
14 care services.
15 **Q.** You say in your statement that you feel you had
16 sufficient understanding and knowledge of the challenges
17 facing the NHS. Clearly those meetings were no doubt
18 a part of that. How else did you gain that
19 understanding?
20 **A.** Well, in addition to the concerns that chairs and chief
21 execs had and the conversations I had with Dr Goodall,
22 I had conversations with Dr Atherton, I had
23 conversations with the chief nurse and the Chief
24 Scientific Adviser for Health, the royal colleges,
25 including the Academy of Royal Colleges and trade

3

1 **Q.** In your role as minister, there are responsibilities set
2 out at length in your statement. I'm not going to go
3 through them all, but is it right that in October 2020
4 your ministerial responsibilities were added to to
5 include the Covid response, screening, vaccination and
6 some other responsibilities?
7 **A.** That's correct, that formalised what was in practice
8 happening.
9 **Q.** Quite. All right. And you are there to set the policy
10 and strategy and, to use your words, hold NHS leaders to
11 account?
12 **A.** Correct.
13 **Q.** Now we know that in Wales you discharged your statutory
14 duty by delegating that to a number of the NHS bodies
15 including the local health boards who are responsible
16 for the operational decisions; is that correct?
17 **A.** Correct.
18 **Q.** All right. And we've heard from Dr Goodall about the
19 power to issue directions, which, as we understand it,
20 are mandatory, but he told us they were mainly
21 financial; is that correct?
22 **A.** Correct.
23 **Q.** Can I ask you, please, you say in your statement that in
24 April and May 2020, you met with NHS chairs and
25 chief executives to hear about the challenges. Can you

2

1 unions, including the RCN and other trade unions in
2 partnership. So issues that we may go on to around PPE
3 for example, around what was happening with testing,
4 those were things that came up in all of those different
5 fora from a slightly different perspective. And,
6 you know, anecdotes about operational practice.
7 So trade unions would sometimes raise issues where
8 they felt that they weren't getting a sensible hearing
9 from the employer and so some of that was about making
10 sure those issues were resolved. And often they were
11 issues that just needed people to have the same
12 conversation at the same time, so -- and there are big
13 strategic issues, and sometimes you can get drawn into
14 what seemed like minor issues but I think are important
15 about delivering trust.
16 **Q.** Could you give us an example of a minor issue that you
17 got drawn into?
18 **A.** Well, they were sometimes just about individual
19 workplace practice and about whether people who were
20 running the organisation and the -- so the impact of
21 that on their staff. So Unite and UNISON raised as
22 examples. I gave an example in my statement actually
23 about where a union had an issue at the Welsh Blood
24 Service, where actually the issue about members of the
25 Welsh Blood Service not using their gloves all the time

4

1 was actually what their members felt they should do.
 2 And that was something where you wouldn't normally have
 3 expected the minister in the middle of a pandemic to get
 4 engaged in that, but that was about a feeling of trust
 5 and people being listened to, and sometimes if you don't
 6 deal with those they can accelerate and become a much
 7 bigger issue.

8 **Q.** I think you also held monthly meetings with the Welsh
 9 ambulance service trust, because in both pre and during
 10 the pandemic, clearly there was a pressure on the flow
 11 through emergency departments?

12 **A.** That's correct. I had -- since I became the cabinet
 13 minister, I'd held meetings through the winter to
 14 understand both before winter where we were, in the
 15 winter and then towards the end, because that is a time
 16 of extraordinary pressure. I know every year people say
 17 there aren't points of pressure, it's year round, but
 18 every winter there are even more extraordinary
 19 pressures, and the ambulance service really were on the
 20 front lines throughout the pandemic.

21 **Q.** I think you are aware that the Royal College of
 22 Emergency Medicine have provided the Inquiry with
 23 a statement, and there was what is said to be an absence
 24 of meetings between either yourself and the Welsh
 25 Government with the Royal College of Emergency Medicine.

5

1 **LADY HALLETT:** Can the public gallery see him?
 2 (Technical problems)

3 **MS CAREY:** We can hear you but we just can't see you on
 4 everyone's screen.

5 **LADY HALLETT:** Is there any way we can find out if those
 6 following on YouTube can -- because if people at home
 7 watching online can follow, we could probably carry on,
 8 if people will forgive us.

9 **MS CAREY:** You are back now.
 10 Can you see and hear me all right?

11 **THE WITNESS:** I can indeed.

12 **LADY HALLETT:** Sorry about that, Mr Gething. Technology is
 13 wonderful when it works.

14 **THE WITNESS:** Indeed, indeed, dim problem.

15 **MS CAREY:** I think we were just dealing with the other
 16 meetings you had in the absence, you say, of
 17 a particular request from the Royal College of Emergency
 18 Medicine, and I was moving on to command and control
 19 structures; all right?

20 **A.** Yes.

21 **Q.** The Chief Medical Officer for Wales has commented that
 22 even when he came into post in 2016 there was a report
 23 which suggested there was "insufficient ability to have
 24 a command and control arrangement within Wales", and he
 25 said that had "bubbled around ever since" and "it was

7

1 Can you help, Mr Gething, as to why you didn't
 2 meet with that Royal College?

3 **A.** Well, I had meetings for a purpose, as did my officials,
 4 and I do think it's worth pointing out is we had
 5 a clinical lead on emergency medicine, who at the start
 6 of the pandemic was also the vice president of the Royal
 7 College of Emergency Medicine Wales. The meetings with
 8 the Academy of Royal Colleges included the Royal College
 9 of Emergency Medicine. I think we had evidence from
 10 Frank Atherton about his meetings with the Academy of
 11 Royal Colleges as well, again including the Royal
 12 College of Emergency Medicine.

13 I don't ever recall receiving a meeting request
 14 from the college to discuss a particular issue, whereas,
 15 for example, when I met the Royal College of Surgeons,
 16 they had a specific request about wanting to restart
 17 elective activity but to do it in a way that took
 18 account of where we were.

19 **Q.** May I ask you briefly about control and command
 20 structures.

21 **UNIDENTIFIED SPEAKER:** Sorry, my Lady, we have lost the --

22 **MS CAREY:** My Lady, I have lost Mr Gething on my screen.

23 **LADY HALLETT:** Oh, I can see him there.

24 **MS CAREY:** It may be that both -- all of counsel's rows --

25

6

1 certainly a feature when Covid hit us."

2 Mr Atherton went on to say that although he was
 3 not critical of the NHS executives, he thought in fact
 4 there needed to be a stronger guiding hand and a move
 5 away perhaps during a pandemic from the collaborative
 6 approach to a more directive approach.

7 And can I ask you, Mr Gething, do you agree that
 8 there was insufficient ability to have a command and
 9 control strategy sufficiently directive?

10 **A.** Well, the problem is this is one of those challenges in
 11 running a whole system, so you can't make every decision
 12 from an office in Cardiff Bay but the reason why the NHS
 13 Executive for Wales was formed was to have a more
 14 central approach. And this was often, actually, about
 15 service change and transformation, which is actually
 16 extraordinarily difficult and you always get people
 17 arguing against local service change because they fear
 18 the loss of something rather than demanding service
 19 change because a better service could be delivered if
 20 only you'd re-organise it.

21 So it was really more in that sense. And when the
 22 pandemic came the collaboration and the directives that
 23 came, the Welsh Government made a whole series of
 24 choices and convening that it wouldn't have done in
 25 normal times.

25

8

1 I'm sure there are lessons to learn about areas
2 where we might have wanted to be even more directive but
3 I think the main lessons are likely things we would want
4 to do differently.

5 **Q.** All right. Can I ask you potentially about an area you
6 may be more directive. By the end of March 2020, the
7 waiting lists for non-urgent elective care were higher
8 than they had been the previous year, and inevitably you
9 knew were going to increase because of the decision to
10 suspend non-urgent elective care. One of the experts in
11 the Inquiry, the hips experts, said that delay obviously
12 in restarting surgery had resulted in not only the pain
13 and disability but for some people a real reduction in
14 their quality of life and waiting times now in Wales are
15 consistently over two years, and they made this
16 observation, that whilst there was the decision taken to
17 cease elective care, there was no top-down mandate or
18 direction in Wales about how the trusts and boards
19 should restart routine elective surgery.

20 Was any thought given to directing the boards to
21 resume a percentage of their pre-pandemic non-Covid
22 work?

23 **A.** Well, the frameworks that were issued, the operating
24 frameworks that were issued after the first wave were
25 actually about getting elective care restarted. I know

9

1 Glangwili hospital and the networks they had there, and
2 compare that to the evidence of Professors Walker and
3 Jenny in UHW, you're operating in quite different
4 contexts.

5 **Q.** Yes.

6 **A.** And if you have a surgical team of six people and three
7 of them are on the vulnerable, and the clinically
8 vulnerable list, telling them they nevertheless need to
9 get 60% efficiency isn't realistic, so that's part of
10 the challenge in understanding the different centres you
11 have, how they operate, and the context, and that's why
12 health boards are responsible for delivering those
13 operational choices. Nobody wants to under-deliver on
14 performance in this area because in normal times you
15 understand people live with discomfort if they don't
16 receive potentially life-changing treatment. Even more
17 so given what happened in the pandemic.

18 **Q.** Can I ask you this then. What did do you as minister to
19 ensure -- forget a lack of percentage or a direction
20 that they must X thousand operations per month -- what
21 did you do to ensure that they were actually fulfilling
22 the advice and direction you'd given them to restart it
23 and restart it as soon as they were practically able to?

24 **A.** Well, after the frameworks were issued you still have
25 the regular meetings with chairs and chief execs and we

11

1 they are covered in my statement and in Dr Goodall's, so
2 actually those were directions issued about having
3 an operating framework. The challenge was we issued
4 those frameworks when broadly the situation was much
5 better than the first wave and then everything got
6 substantial worse through the autumn and the winter.

7 And the challenge always, and this comes back to
8 why, when you talk about service reform you're dealing
9 with inconsistency in delivery. You're dealing with
10 very local models of care and how you get greater
11 consistency and efficiency and, with respect, I don't
12 think those things are linked to the pandemic. I think
13 those things are about a more general challenge in
14 delivering health service transformation and reform as
15 opposed to the choices we made directly in the pandemic.

16 **Q.** The quality frameworks of which you speak did obviously
17 urge the boards to restart but it never said to them: do
18 50% this month, 60% next month, or add 100 every month,
19 and I think what the experts were saying is it perhaps
20 needed that particular direction being given to them to
21 help encourage, if not enforce, the resumption of
22 non-urgent elective care.

23 That's the point I'm getting at.

24 **A.** I'm not sure that works in practice. If you want to --
25 for example, think of the evidence of Phil Kloer and

10

1 did discuss what they would do on restarting that
2 activity. The problem is after we issued the
3 frameworks, Covid started to rise significantly, so our
4 ability to restart the non-Covid part of it actually
5 gets more compromised but by then, and again you see
6 this in the evidence of Phil Kloer and the respective
7 medical directors for Cardiff and Vale Health Board and
8 others, you are starting to see the ability to try and
9 have segregated red and green lanes as well. So you're
10 trying -- and this, again, was something the Royal
11 College of Surgeons urged to try to have a green zone,
12 where you can try and undertake this more elective
13 activity with the backlog that we know is building up,
14 and a red zone where you know, actually, you have to
15 take more precautions and that means your efficiency is
16 compromised.

17 **Q.** Can I ask you this, do you think that in a future
18 pandemic there should be contingency plans which include
19 a strategy or a plan, call it what you will, for either
20 the continuation of elective care or at least the prompt
21 recovery of it?

22 **A.** I think it's helpful to try to learn lessons from what
23 worked well here and what didn't and the challenges you
24 have to go back to, what's the scale of your challenge
25 at the start, how can you then operate safely in

12

1 elective areas, an (inaudible) pandemic might not be
2 this one. The challenge of having enough testing and
3 understanding how you operate safely and the estate we
4 have are things at the time, but to understand how we
5 got to restart at this point and what we might do
6 better, I think is definitely well worth learning and
7 try to understand how we don't simply accept there'll be
8 a very large backlog and there is nothing we can do
9 about it.

10 **Q.** Can I ask you then about some of the challenges. In
11 your paragraph 58 you make the observation that your
12 primary focus was to save lives and protect the NHS.
13 And can I ask you, what did you mean by the phrase
14 "Protect the NHS"? It's your paragraph 58, Mr Gething.
15 **A.** I think we're really talking about, and this does go
16 back to, I gave this evidence in Module 2B as well, what
17 had happened in northern Italy really affected me,
18 a first world country with a first world healthcare
19 system that was plainly overwhelmed, with people lying
20 in corridors in a way where the care was neither
21 dignified nor appropriate, and that really bothered me.
22 How do you make sure that doesn't happen? It isn't just
23 about those individuals, I think they'd have a much
24 wider shock and impact in wider society outside the
25 health service as well. So I was always concerned to

13

1 this correctly that, for you, if someone didn't get
2 an intensive care bed or wasn't able to be put on
3 a ventilator, that would be an indication that the NHS
4 in Wales was overwhelmed?

5 **A.** It's an indication that it's being overwhelmed. In more
6 times you have challenges on staff ratios and some
7 services and they're operating under some stress. What
8 you'd have seen if the whole service was overwhelmed was
9 that you'd have seen large numbers of people not being
10 able to get appropriate care, including people where the
11 NHS could and should be able to act to save their lives.
12 Now, that was the nightmare scenario because actually
13 the harm done to staff who were going into work in those
14 situations would be even more significant than the harm
15 that we know that our staff are living with now from
16 what did happen.

17 **Q.** We'll come on to look on the impact on staff in
18 a moment, but can I ask you this. Do you consider that
19 during your tenure as minister, the health system in
20 Wales became overwhelmed at any point?

21 **A.** No, but that's only because we took extraordinary
22 measures. If we'd tried to run the system as normal
23 then it would have been overwhelmed. That's why we had
24 to take a measured process to turn off parts of the
25 service, we needed to change it to allow the service to

15

1 make sure that the NHS didn't get overwhelmed in that
2 way and that meant that we had to turn off parts of the
3 NHS for that to happen. None of that is comfortable and
4 none of that is harm free, but a much greater harm would
5 have been what we saw in northern Italy.

6 **Q.** What did you understand the NHS overwhelm would look
7 like? No more beds? No more ICU beds? No GP
8 appointments? What did it mean to you?

9 **A.** Well, I thought it could mean everything that we'd seen
10 on our screens. And it's hard to overstate how shocking
11 some of the predictions were about what might happen.
12 If you really can't have intensive care beds, if you
13 really have people who need and would benefit from
14 invasive ventilation and you can't do it, then,
15 you know, more people dying than potentially need to and
16 they die in a very undignified and harmful way itself as
17 well, and that then has a ripple into every other part
18 of the service.

19 If you look at what we did, there was a ripple
20 into every part of the service as well. If your main
21 part in the hospital system can't cope and is
22 overwhelmed in that way, that ripple is even more
23 significant and we'd have lost more lives from the
24 public and from our staff as well, if that had happened.

25 **Q.** So do I understand you correctly to -- do I understand

14

1 still function, and in particular those people with
2 extraordinary need that we saw in both waves 1 and 2.

3 **Q.** Can we have a look at some of those measures during the
4 course of the next part of your evidence.

5 And can I start with the framework that you
6 published on 13 March and perhaps if we could have
7 a look at your paragraphs 108 and 109 in your statement,
8 Mr Gething.

9 Can we have on screen, please, INQ000474242_32.

10 If it helps you, Mr Gething, we have them on the
11 screen.

12 The framework there was published at 4 o'clock on
13 13 March. It set out a number of recommendations for
14 action which included the suspension of non-urgent care,
15 the prioritisation of using non-emergency patient
16 transport services, to focus on discharge, expedition of
17 discharge of vulnerable patients, and a number of other
18 measures that we're familiar with to all try and plan
19 for what was thought to be coming down the track.

20 Is that it in a nutshell?

21 **A.** Indeed. That shaped just some of what was happening.

22 **Q.** Can I ask you this, why was this framework not made as
23 part of a direction but was, in fact, just essentially
24 recommendations for local health boards as to how to
25 respond?

16

1 **A.** I think that underplays the significance of doing this
2 in any event. We had a real discussion about whether
3 I should simply direct people to do this or whether it
4 was preferable to issue a framework to allow this to
5 happen and that, again, comes back to the different
6 contexts that health boards are operating in.

7 Again, I know Phil Kloer indicated that in West
8 Wales the pandemic arrived a little later than in East
9 Wales, for example, so the measures taken in different
10 health boards were different but also, if you look at
11 North Wales -- north-east Wales and north-west Wales,
12 they'd have needed to do different things to get ready
13 for what was happening and that was in the same health
14 board.

15 **Q.** All right.

16 **A.** So there was a real discussion and consideration of it,
17 but issuing the framework in itself was an extraordinary
18 measure. This is announcing that standard parts to the
19 health service are going to be turned off and that is
20 not a usual thing to do. I remember the press
21 conference in announcing this and just getting the
22 dawning realisation of how significant this is going
23 to be.

24 **Q.** I follow that. You don't want, for example,
25 a West Wales hospital that hasn't been hit yet

17

1 you say in your statement, 145 level 3 critical care
2 beds?

3 **A.** I can't recall exactly. But I think there's the adult
4 beds with some for children but, yes, nothing like what
5 we're told we might get.

6 **Q.** Do you consider that entering the pandemic with high bed
7 occupancy and fewer critical care beds for the size of
8 the population in Wales meant that the Welsh hospitals
9 had to surge all the more and put them under even more
10 strain?

11 **A.** There was a huge surge that was potentially required.
12 And if you then go back to the pre-pandemic healthcare
13 system, and I think there's quite a lot about wanting
14 more capacity in more areas and our bed numbers compared
15 to European comparators including on critical care, but
16 that requires investment over a longer period of time
17 not just in staff but in the physical layout of your
18 hospital buildings as well. So it did leave us with
19 greater vulnerability than if we were in better
20 position. I think that's undeniable.

21 **Q.** I think Dr Goodall told us that pre-pandemic occupancy
22 was regularly around 100%?

23 **A.** Correct.

24 **Q.** All right. How did you ensure that there was going to
25 be sufficient critical care capacity given the vast

19

1 suspending elective care before they absolutely need to.
2 So is that an example, you would say, of why you don't
3 make it directive but you gave this as a framework as
4 opposed to a mandatory order to the boards?

5 **A.** Correct. The situation in West Wales would be very
6 different from Gwent, very different to Gwynedd, so if
7 you have a one-size-fits-all, then you know you'll make
8 things worse in some parts of the service where you
9 don't need to.

10 **Q.** Now, the briefing that underpinned the announcement of
11 the framework, included, did it not, a reasonable
12 worst-case scenario that critical care capacity simply
13 was not going to match the level of critical care that
14 was likely to be required in Wales?

15 **A.** Yes, that was one of the very difficult things. At that
16 point, the modelling was on behavioural science and the
17 expected response of the public, so yes, it was a moment
18 of very real concern for everyone across the healthcare
19 system.

20 **Q.** I think briefings -- well, the reasonable worst-case
21 scenarios varied, clearly, but at one stage it was
22 suggested that there needed to be a 30-fold increase in
23 critical care beds in Wales and I think, in due course
24 the reasonable worst-case scenario in April reduced that
25 to 900 ICU beds required in Wales and you had, I think

18

1 increase in critical care beds that were needed,
2 whichever reasonable worst-case scenario you look at?

3 **A.** That was partly the reason for the framework. If you're
4 going -- and at that point we thought the peak would
5 come later and I think I said this in my statement, as
6 in others, about a single peak was expected and we
7 thought we were a good deal more weeks away from the
8 peak than we were in fact. So, actually, if you don't
9 take an approach to try to manage reducing other
10 activity in your system, you can't redeploy your staff,
11 retrain them, and actually get all the resources in
12 place that you need. So there had started to be
13 anecdotal calls from different people but also, and this
14 goes back to some of your earlier questions about
15 chairs, chief execs, and engaging with them,
16 a realisation that we actually need to do something that
17 is more significant than sending a couple of people on a
18 training course.

19 **Q.** The framework, though, did not provide a model or
20 an estimate of the number of beds that you were looking
21 to free up or that would be required, did it?

22 **A.** No, because again that would have been us trying to
23 numerically manage things in a way that would have been
24 artificial but it was about, you've got to turn off lots
25 of this activity to be able to have a plan about how you

20

1 then retrain people as well, and that was more apparent
2 in, if you like, the three south-east health boards, so
3 Cwm Taf Morgannwg, Aneurin Bevan, and Cardiff and Vale,
4 because they were -- by 13 March, that's where we were
5 starting to see numbers coming that we were anticipating
6 to come in, so actually they were much more interested
7 in how quickly they could flex, but also, because of the
8 hospital infrastructure in those areas as well, with UHW
9 being the biggest hospital in the country by a long way
10 as well.

11 **Q.** Can I ask you this, if you're going into the pandemic
12 with 145 ICU beds and you know that the modelling says
13 you need 900, how were you going to get that surge if
14 you don't tell the boards: we need another 750 beds?
15 You need to provide 100, Cardiff, you need to provide
16 100, Morgannwg, et cetera, et cetera, how were you going
17 to ensure you were going to get the 900 if you don't
18 tell them you've got double your capacity or triple it,
19 or you have got to provide another 100 beds?
20 **A.** Well, actually, the planning assumptions around that
21 weren't in the framework but those conversations were
22 taking place between Dr Goodall and the system and the
23 system in itself. So the critical care network in Wales
24 wasn't unaware of the reasonable scenario assumptions,
25 and that's part of the reason why lots of people engaged

21

1 scenario comes to fruition?
2 **A.** Well, there are two things. The first is in normal
3 times I have regular contact with Dr Goodall as the
4 chief exec of NHS Wales and director general. In the
5 pandemic that's then daily contact about what's
6 happening so there are regular conversations between --
7 and this is part of it.

8 The second thing is, the honest truth is that no
9 one can give you the direct assurance that we can have
10 900 critical care beds in place by a certain point in
11 time. All of your planning and your assumptions are
12 about how you maximise what's possible but it's
13 dishonest to say I was assured we would have
14 900 critical care beds in place by the start of May
15 because there are so many moving parts and that's partly
16 the worry in making choices. But even if you make the
17 best possible choice available to you, it's still
18 possible that you could live through the disaster you're
19 trying to avoid.

20 **Q.** Did you get any updates as to how the capacity increase
21 was going? Did they say to you, for example, we're
22 two weeks now on from the framework, we've got 100 extra
23 beds, or 200, or whatever the figure was?

24 **A.** Yes, I think you've seen some of Dr Goodall's updates
25 that he provided to me, the daily updates, so that does

23

1 in critical care were actually saying you need to do
2 something and do it earlier rather than later to give us
3 the capacity to flex up for what might be coming.

4 So, you know, and I'm sure it's in Dr Goodall's
5 evidence and in Judith Paget's evidence as well, because
6 she was the chief exec of Aneurin Health Board at the
7 time we are talking about, about the way in which they
8 understood need to flex up and to build up their
9 capacity in this area and that meant you have to turn it
10 off somewhere else to have the bed stock available and,
11 crucially, the staff available to deliver the care.

12 I think the other point about the reasonable
13 worst-case scenario, of course, is that that is
14 a reasonable worst-case scenario if all of your other
15 measures don't work and that's the challenge, I think,
16 about your planning assumptions and not being able to
17 assume that everything will work, and what the sort of
18 public response is for something we haven't had to live
19 through before.

20 **Q.** What I wanted to try and understand, though, was how you
21 were satisfied there was going to be sufficient critical
22 care capacity. I understand Dr Goodall is having these
23 conversations but you, as minister with overall
24 responsibility, how did you know, don't worry, we're
25 going to have enough beds, if the reasonable worst-case

22

1 show that not only was there a daily conversation with
2 him, but I'd look at those sort of figures each day to
3 see what were they reflecting, what was coming through
4 the door, what capacity is being created, and so that is
5 happening in realtime.

6 I'm sure the Inquiry has available to it all the
7 data and I think they just had examples of it but there
8 is a regular conversation, if not a daily one, between
9 myself and Dr Goodall. I saw more of him than my wife
10 on most days.

11 **Q.** We have more data than we need on those days, I suspect,
12 so I hear you there.

13 Can I ask you this, you say this in your statement
14 that at no point during the pandemic were bed capacity
15 limits breached in Wales, the highest overall occupancy
16 rate during your tenure was 86% during September 2020.
17 This included critical care beds, acute beds, field
18 hospitals, private hospitals, community hospital beds
19 but additional surge capacity remained available.
20 Reporting, as I understand it, though, is done
21 nationally. Do you know what the position was in any
22 given health board as to how close or otherwise they
23 were to being full?

24 **A.** Yes, I think I have set this out in my statement.

25 Cwm Taf Morgannwg did get really full and that shouldn't

24

1 really be a surprise because when you think about the
2 hospital estate but also it's the health board in Wales
3 with the largest concentration of least advantaged
4 communities. We know Covid didn't strike communities
5 evenly. So, actually, there was real worry. So there
6 was mutual aid moved around, as well, but that also goes
7 into harm, I'm sure we'll discuss later on, for staff of
8 what they're seeing and what they're doing.

9 And the statement that we didn't breach capacity
10 is true but it comes at a cost because you had to turn
11 off other parts of the service and, again, it looks
12 different in different parts of Wales. I think
13 Phil Kloer said that they never had to move away from
14 1:1 ratios in intensive care, whereas a statement from
15 the medical director in Cardiff said that those were
16 stretched, and I know that Professor White has indicated
17 that too. So there is capacity, there is a bed
18 available, but actually your resources are significantly
19 stretched and redeployed.

20 **Q.** A number of things there, please, Mr Gething. You
21 mentioned Cwm Taf. I think you say in your statement
22 that Prince Charles hospital in Cwm Taf came close to
23 declaring CRITCON 4 as they had exhausted all their
24 capacity but there was still limited capacity in
25 neighbouring local health boards. Were you informed of

25

1 capacity they primarily managed at that hospital
2 through dilution of nursing ratios run through
3 transfers out through the whole period in question."

4 Can you help me, what were you made aware of about
5 the state of critical care transfers between either
6 boards or intraboard during the course of wave 1?

7 **A.** So I didn't have a report that said: here are the number
8 of transfers that have taken place. It was a more
9 general: here is what we're doing and how we're coping
10 and this is what we're doing and having conversations
11 between staff. So I knew the Critical Care Network
12 would discuss things within its board but also across
13 Wales as well, and that's the point about mutual aid.
14 It isn't a managed central network but it is
15 nevertheless a network of people who understand the
16 pressures other people are coping with.

17 If Cardiff and Vale, for example, had wanted to
18 transfer patients and ask mutual aid then they could
19 have done that and they would have understood how to do
20 that. It's about how you cope. And that's one of the
21 things I think is really important, it's about how you
22 cope with what is taking place around you, and the
23 various health boards have set out how they did that.

24 **Q.** If the ratios are stretched, though, 1:2 or above, as
25 they were at the University Hospital of Wales, do you

27

1 how close Cwm Taf came to the brink? Is that
2 information you get?

3 **A.** Yes. Both from Dr Goodall but also I'm sure it was
4 mentioned by Frank and his deputy Chris Jones, because
5 they were close to the system as well. So the system in
6 Wales is fairly small and that means that relationships
7 with chairs and chief execs and the staff around, it
8 isn't, if you like, the arm's length way that England is
9 managed because it's a much bigger unit.

10 **Q.** Different size. Understood.

11 Now, you also mentioned in there though references
12 to the ratios and, you're right, Mr Kloer gave evidence
13 that they didn't breach the 1:1 ratio, University
14 Hospital of Wales said this:

15 "During the first and second waves ICU nurses
16 frequently worked outside the usual ratio at a ratio of
17 1:2 or above. In wave 2 there was very limited support
18 staff available to assist."

19 In fact they had lost the number of staff from the
20 first wave which obviously placed demands on them, and
21 they say this:

22 "Very few patients were transferred to other
23 critical care units. Unlike in English, Wales'
24 Critical Care Network is not an operational network.
25 Although they had meetings where they were over

26

1 agree, Mr Gething, that it is likely people were getting
2 less than optimal care than they would have done
3 pre-pandemic times?

4 **A.** I can't honestly tell you that that definitely did or
5 definitely didn't happen, because in terms of the
6 outcomes, and outcomes that you'd have expected,
7 I haven't looked at that, but actually there's a risk,
8 that's why there are ratios in place, to make sure you
9 can give assurance about the quality of care provided,
10 but I wouldn't want to invent an answer for you counsel.

11 **Q.** No, I'm not asking you to either but we've heard
12 evidence that once you stretch the ratios, inevitably
13 the attention to detail, which is the hallmark of
14 intensive care medicine, inevitably gets diminished and
15 in doing so you're not providing the same level of care.
16 It follows, doesn't it, that if the ratios are stretched
17 in the way that this hospital had to do, people are not
18 getting the same type of care that they got
19 pre-pandemic?

20 **A.** Well, there's an obvious risk not just in the type of
21 care with the nurse ratios but about the outcomes,
22 there's an obvious risk of different outcomes, and that
23 is partly, I'm afraid, what coping looks like when
24 you're flexing up numbers and you have more people who
25 are seriously unwell coming into your system.

28

1 Q. So if I understand your evidence correctly, you consider
2 that people that needed intensive care got it, albeit
3 with the acknowledgement it may not have been the same
4 level as at a pre-pandemic time. Is that a fair
5 summary, Mr Gething?

6 A. Yeah, I think that is because, you know, in some parts
7 of system the nursing ratio, the ratios of staff weren't
8 the same, and I think it's important to recognise that,
9 actually, that that's how our system coped with the
10 extra demand that came in.

11 Q. Can I ask you about one of the quotations given by
12 a critical care doctor in Wales to the research that
13 the Inquiry undertook.

14 Can we have on screen, please, INQ000499523_22.

15 Mr Gething, this cannot be and nor is it suggested
16 on behalf of the Inquiry this is necessarily
17 representative. I hope you will take that into account
18 but here is a critical care doctor who told the
19 researchers:

20 "We knew it wouldn't help because we had come to
21 see what kind of people died of this disease despite
22 escalated care. So we decided not to admit to
23 critical care whereas had they had a different
24 illness, they probably would have been more likely to
25 benefit so we would have escalated. We didn't have

29

1 not specifically, but even in this anecdotal piece of
2 evidence, that there were choices being made directly
3 about whether people were going to be admitted to
4 critical care is different to whether people admitted to
5 non-invasive ventilation, CPAP, which is a different
6 choice based on clinical evidence, but this suggests
7 something different.

8 Q. May I just look briefly at one of the measures you took
9 to try and make sure there was capacity and it's the
10 issue of field hospitals in Wales. I think you say in
11 your statement that you were essentially responsible for
12 ensuring there was the funding for the field hospitals
13 and providing strategic oversight, your words. Can
14 I ask you, what strategy or strategic oversight did you
15 provide?

16 A. So this is part of the planning assumptions and so
17 I would have talked to Dr Goodall about where we are,
18 about the likely challenges we'll face, about reasonable
19 worst-case scenarios and what we need to provide for,
20 and the field hospital network is part of doing that and
21 you will see that the network shifted over time with the
22 capacity in it. To provide a field hospital you need
23 a building to do it in and you need to have some staff
24 to provide for it as well, and I think you have evidence
25 in front of you about the different model we had in

31

1 enough space to give people a go who had a very remote
2 chance of getting better. If we had had more
3 capacity, we might have been in a position to try."

4 Were you aware of anecdotal or conversations that
5 were taking place that suggested some people didn't get
6 a chance to get intensive care when otherwise they might
7 have done?

8 A. No. And that's very upsetting to read because that's
9 a direct impact on an individual but also on a staff
10 team who are making those choices.

11 Q. Do you think there ought to be a mechanism in Wales
12 where that kind of frontline, very visceral experience
13 is relayed to Dr Goodall, Mr Atherton, and the minister,
14 so that they do appreciate that whatever the data says
15 there are the most heartbreaking decisions being made on
16 the front line?

17 A. Well, some might come to the networks that do exist, so
18 Dr Atherton talking to medical directors, I would expect
19 medical directors to be aware of what's happening on the
20 front line. You know, Dr Kloer was a respiratory
21 physician so, you know, I know that he would have
22 thought about this himself. That's the same position
23 for other medical clinicians and their specialities.
24 I did know that heartbreaking choices were being made
25 because I knew that was inevitable and unavoidable but

30

1 Wales about step up, step down, and not suggesting we'd
2 use field hospitals for extra intensive care which
3 I think was the right call.

4 So I would then have to go and make a case to the
5 Star Chamber for additional support and I think in my
6 statement I set out there was some push back from the
7 Star Chamber about the scope and scale that was
8 required. So I think that shows that scrutiny is real.
9 And then the network is created and then after the first
10 wave we then have a different and a smaller network of
11 field hospitals available based on our experience going
12 through the first wave as we're going into the second
13 one.

14 Q. Obviously you make the point that once they were built
15 and funded, which was -- really you're responsible for
16 getting the money in, if I can put it like that, the
17 operational decisions about how they were used lay with
18 the health boards; is that correct?

19 A. Yes.

20 Q. Can I ask you, did you check as to how the field
21 hospitals were being used?

22 A. Yes, I took an interest. So I knew that in the first
23 wave we'd only had, I think, two or three field
24 hospitals being used. So then in the operational --
25 then in the discussion I had with Dr Goodall about

32

1 planning for what was coming next, taking account of the
2 fact we'd had field hospital capacity created that
3 wasn't used and then what would it look like, and that
4 then shifted again as we go into the second wave and we
5 then get vaccination available. So the mission of the
6 field hospital building changed a bit, but in the second
7 wave we did see more people going through the step down
8 care in particular in field hospitals that we couldn't
9 have done on the acute hospital sites that we had.

10 **Q.** Given that it was a different model in Wales for
11 step down care, was any thought given to using them for
12 non-Covid care or for the re-establishment, for example,
13 of elective care, particularly in wave 2?

14 **A.** I think the problem with that is that, you know,
15 elective care often still requires a theatre. And if
16 you require a theatre I don't think a field hospital is
17 the place to go. That's when you're really at: this is
18 the only thing left to do before the whole system
19 collapses.

20 So the point about rehabilitation and about
21 recovery, that sort of side of step down care, they do
22 make sense, because otherwise you can't do anything.
23 Some of your outpatient appointments could be used there
24 as well. So there are probably other parts of the
25 system and how they can work, yes, but not, I think,

33

1 there was always an element of mistrust and people were
2 essentially bidding up for the next stage of PPE
3 protection, so understanding the volumes of each item,
4 how that related to the guidance and recommendation made
5 about appropriate PPE, and where and how you get it, and
6 for me -- and I've said this before -- in April this was
7 a bigger issue for me than testing because our
8 understanding of the utility of testing at the time was
9 different and the capacity of testing at the time was
10 different but if you run out of PPE, if you're frontline
11 staff, then you're in real, real trouble.

12 **Q.** A number of things I want to ask you about that answer.
13 Can I just ask you this, who was it or which institution
14 was it that led you to believe that FFP3 was more
15 protective than the surgical mask?

16 **A.** It was the conversations I had both with Chief Medical
17 Officer office but also then, just in the conversations
18 about supply, so understanding why we had different
19 grades of mask on the supply. So that would be both
20 with -- so, Simon Dean and Alan Brace, who were finance
21 director and deputy chief exec of NHS Wales
22 respectively, but actually those don't really reflect
23 what they were doing. Alan Brace undertook lots of the
24 work with me on the stocks that we had and what they
25 were for and because he'd been in a health board before

35

1 when it comes to restarting elective lists.

2 **Q.** Different topic and that of PPE, please.

3 You say in your statement that you were the lead
4 minister responsible for PPE. Can I ask you this. Did
5 you understand that FFP3 masks were more protective than
6 the FRSM blue masks?

7 **A.** Yes, and I had to learn quite a lot about this really
8 quickly because previous to being a minister I hadn't
9 taken much of an interest in the difference between
10 masks, but understanding the difference was quite
11 important when it came to numbers and stock.

12 **Q.** And when you came to learn it, when was that?

13 **A.** I can't give you a date. I'd be making that up. But
14 actually as we got -- we issued the pandemic stock that
15 we had. So we had a pandemic reserve that was part of
16 a UK arrangement. And actually we thought we had
17 six months' supply. That's what the stock was supposed
18 to be for and of course we went through that a great
19 deal faster than six months. So the urgency of PPE was
20 there throughout wave 1. And certainly by the end
21 of March, early April, it was a growing concern because
22 we could see that we were burning through our stocks in
23 usage terms and then all the points about what is
24 appropriate, and people were fearful.

25 So the recommendations on appropriate PPE to use,

34

1 directly he understood a great deal about the operation
2 of the service, not just from the financial level but
3 the value you got from it, and so I had to pretty
4 rapidly learn the different grades of equipment that we
5 had and what that meant for staff.

6 **Q.** I think you say in your statement that at a national
7 level you did not run out PPE; is that correct?

8 **A.** That's correct, we had some very real challenges in
9 distribution so --

10 **Q.** You say in your statement also there were initial
11 localised challenges and I wanted to know what did that
12 actually really mean, Mr Gething?

13 **A.** There were reports -- some of this came from trade
14 unions as well as from some of the chairs and chief
15 execs in health boards about not being able to get PPE
16 to frontline staff. They had been concerned and worried
17 about PPE reaching them. And I think I also saw a news
18 report that suggested in one part of the system at one
19 point people were wearing refuse liners because they
20 couldn't get gowns.

21 Now, that's not comfortable at any point in time
22 particularly when there's a pandemic running. And
23 actually to then see on a national level we think we
24 have stocks, it's then about why isn't that stock
25 getting to people on the front line, and so those are

36

1 questions that I don't just ask Dr Goodall or
 2 Alan Brace, those are questions then about, well, I need
 3 to know this is happening. And, actually, it came to
 4 not so much about how the distribution worked, so part
 5 of the reason we used a joint -- the joint service
 6 depots that local authorities ran, was that you then had
 7 more localised depots of things as well, because of
 8 course we had to supply social care too.

9 So each of those areas where it appeared that
 10 stocks hadn't got to the front line was a concern for me
 11 because, again, you still get into inadequate PPE should
 12 not be what our staff are expected to deal with, even if
 13 we think we have national stocks available, but if you
 14 have run out nationally then that really is into the
 15 scenario where you know you've got to have all the staff
 16 you need because you can't protect them.

17 **Q.** All right, a number of things I'd like to ask you about
 18 that.

19 Can I just take a step back to the pre-pandemic
 20 stockpile. I think you've told the Inquiry in previous
 21 modules that PPE stockpile planning was incomplete and
 22 that the plan, as we know, was for a flu pandemic, and
 23 had you had a flu pandemic you would have found it
 24 difficult and, of course, extra so given that, in fact,
 25 it turned out to be a Coronavirus pandemic.

37

1 least 15 weeks; is that right?

2 **A.** Yeah, even at the time we thought it would do, and you
 3 can see here that it didn't.

4 **Q.** Yes, exactly. If we look at the gloves about which you
 5 were just speaking, you can see that the stock there was
 6 at the 1 March, and from the week of 9 March you had one
 7 and a half weeks, it only lasted one and a half weeks?

8 **A.** Yes.

9 **Q.** That's probably the worst example on that page, but one
 10 can see there, again, nothing like the 15-week supply
 11 that you thought you would need to get through the
 12 initial stages of the pandemic.

13 So, clearly, going into the pandemic there was
 14 an inadequacy in the stockpile, with which I think you
 15 agree?

16 **A.** Correct. Although actually, once we got on top of
 17 gloves, aprons were a bigger issue. But I spent lots of
 18 time worrying about this and it did take up
 19 a significant portion of my time as a minister in
 20 understanding where we were, where our supply lines were
 21 and, you know, our arrangements with other parts of the
 22 UK as well in purchasing this as well.

23 **Q.** I think in fact -- you said aprons but I think it was in
 24 fact gowns. Dr Goodall said that you were down to about
 25 two days' supply of gowns across Wales.

39

1 Dr Goodall told us last week that the supply set
 2 aside was inadequate for a Coronavirus. Would you agree
 3 with that?

4 **A.** Yes.

5 **Q.** Can I understand from your perspective, did that mean
 6 you didn't have the right PPE or didn't have enough of
 7 the right PPE or both?

8 **A.** I think it was a bit of both. So I think there's the --
 9 I think I covered it in my statement where some of the
 10 eye protectors were just not fit for purpose and so some
 11 of them had to be destroyed, which is not at all
 12 comfortable, and that was from the pandemic stock.

13 And it's also about understanding the different
 14 grades of protective equipment you've got and how
 15 quickly you're running through them as well.

16 So I know there is a lot of focus on masks but at
 17 one point we were worried about gloves as well.

18 **Q.** Yes, I was -- exactly -- going to ask you about that,
 19 Mr Gething.

20 To help you and those that are following, can we
 21 have up on screen, please, INQ000214235_21.

22 This is a report from the Auditor General about
 23 the procuring and supplying of PPE that was done in
 24 April 2021 but it looked back to 2020. And I think the
 25 plan was for the stockpile and other supplies to last at

38

1 Putting aside the national position, where you had
 2 enough, were you able to monitor what stock was held by
 3 each health board?

4 **A.** Not personally, because the figures I had -- I looked at
 5 the run rate. I eventually had figures about overall
 6 stock supply, then at the run rate that they were being
 7 issued, and then actually it was for health boards and
 8 local authorities to make sure that stock was
 9 distributed locally. If I tried to manage that or
 10 create a unit to manage that individually, I think we'd
 11 have stopped the system from working, bluntly.

12 But understanding the run rate that we had, so
 13 that was -- so how much we were actually going through
 14 as opposed to what we thought we'd go through, how does
 15 that mean we need to procure, and are we getting enough
 16 as well. I think the Audit Wales has lumped together
 17 aprons and gowns as opposed to seeing them separately --
 18 but understanding the types of items we needed.

19 And, you know, with testing and with PPE there
 20 were frankly an awful lot of shysters who were trying to
 21 make money out of inadequate equipment. The whole world
 22 wanted more and some people saw that as an unscrupulous
 23 business opportunity, including inadequate equipment.

24 So the systems we had weren't just about buy
 25 anything, it was about buy what we need of the stuff

40

1 that can actually be used. And in the early weeks and
2 the very real anxiety, we eventually got to a point
3 where we were able to do that, but also the publication
4 of stock I think helped with people's confidence about
5 where we were, and that we were being upfront about it
6 as well.

7 **Q.** I didn't mean to interrupt you, Mr Gething, but it may
8 be her Ladyship's procurement module will look those
9 that sought to take advantage of the difficulties of
10 which you spoke. But can I ask you about a difficulty
11 that was brought to your attention.

12 Can we have up on screen INQ000299062_7.

13 It's an email sent to you, Mr Gething, from
14 a consultant at a hospital on 24 March, so very early on
15 in the pandemic, and the sender says:

16 "Complete chaos at our hospital.

17 "No protection for nurses -- very low [morale]
18 as being asked to care for patients admitted to
19 Orthopaedic wards by medics with respiratory symptoms.

20 "Masks not being released."

21 So a direct line in to you there of some very
22 real problems in that particular hospital.

23 What did you do, personally, to follow up on this
24 and ensure that the problems being spoken of in an email
25 like that were in fact being resolved?

41

1 **Q.** Okay.

2 **A.** So, as I say, the system is small compared to England,
3 so there are people, when you go around and visit, you
4 meet them two or three times, so eventually they feel
5 they can trust you and tell you things. But in the
6 pandemic I did not get a -- regular point-of-contact
7 emails from consultants, including those that I'd met,
8 saying "This is the problem I have in my workplace, can
9 you do something about it?" It's part of the reason
10 that I took it seriously, was this was an unusual
11 intervention from an area of the country that we
12 expected there to be real concern, because of the
13 socioeconomic grading we expected (unclear).

14 **Q.** You mentioned there I think the TUC bringing issues to
15 your attention. I think one of the things they say in
16 their statement to the Inquiry was that some workers had
17 to resort to wearing bin bags or buying visors, goggles
18 and hairbands on which to hook poorly-fitted face masks.
19 In some places, home-made PPE was donated to workers,
20 the use of which was available sometimes increased their
21 risk of infection and in some cases led to workers being
22 reprimanded.

23 Mr Gething, we also heard from Jonathan Rees,
24 a pharmacist, who, amongst other things, told us that
25 a local school's DT department started making masks and

43

1 **A.** Well, I think the email trail that you have shows that
2 I didn't just pass the message on and say "Please deal
3 with this", it was a conversation that I then had with
4 our officials, with Dr Goodall and others, about "Where
5 are we? What's happening?"

6 And actually, as a minister, when you poke and
7 prod and say "I want to know this", it does almost
8 always deliver a response. So the work that we then had
9 to do on -- because often you just assume that PPE is
10 veil. As a minister you don't normally say "I want to
11 see all of this personally". Then, understanding there
12 is an issue both with how the system's being run, how
13 staff feel, but with PPE as part of it, as a specific
14 part of that -- and I got not just interested but I did
15 something about it, as the email trail I think shows in
16 the rest of the document, and it did lead to a greater
17 structure being put in place where I then had regular
18 updates about PPE stock, how it was done, and it led to
19 me making choices about publication. Not just this
20 individual but this was an issue that was raised
21 consistently by trade unions in the first couple
22 of months as well.

23 **Q.** Yes. Can you help, how often did you get an email like
24 this, Mr Gething, across your time as minister?

25 **A.** Rarely.

42

1 their own hand gel to provide it to the pharmacists.

2 Were reports like that being brought to your
3 attention throughout waves 1 and 2?

4 **A.** Yes, so in wave 1, not in wave 2.

5 **Q.** Right.

6 **A.** So in wave 1 I'd seen a news report of bin bags being
7 used, which really did concern me. And the email you've
8 just brought up is from the start of -- well, the start
9 of lockdown, March 24th. We'd just gone into lockdown.
10 And -- so, yes, that was part of the reason I took
11 an extra interest.

12 When we got into wave 2 actually, our procurement
13 and delivery systems I didn't get anything like the same
14 concern at all, and we'd had regularised use of other
15 parts of our system that were making products. So hand
16 sanitiser is probably the easiest example, because lots
17 of people made it, lots of breweries and distilleries
18 ended up making lots of hand gel. You know, I've still
19 got -- still got hand gel items around the house from
20 all the people that made enormous amounts of it. And
21 the making of the visors as well.

22 So lots of that happened and we had a call-out to
23 the private sector to help us with it. We also had the
24 materials of (unclear) that looked at items to make sure
25 they could be quality assured. So in wave 1 it was

44

1 a real concern, particularly in the first half of
2 wave 1. Then we had regularised and managed to get
3 enough supply in, including mutual aid from other parts
4 of the UK, that we both received and contributed to.
5 And then I think it was on a more even keel. But it was
6 one of those things where people were always concerned:
7 have I got the right PPE, and will I have access to it
8 when I need it?

9 And that's why the publication of the stock
10 levels -- that came from a conversation with trade
11 unions. So the RCN, UNISON, Unite, the GMB and the
12 smaller unions, including the ones representing
13 therapists. Those conversations mattered because it did
14 lead to the assurance that I think made a difference.

15 **Q.** Given the concerns that were raised to you, whether it
16 be by email, in conversations with TUC, with other
17 stakeholders, do you accept that at times in wave 1 it
18 appears that healthcare workers in Wales treated
19 Covid-19 patients with inadequate PPE at potential risk
20 to their own health?

21 **A.** I'm afraid that's possible, yes.

22 **Q.** Finally on PPE, were you aware of issues that FFP3 masks
23 did not always fit women or did not fit people from
24 a non-white ethnicity?

25 **A.** Yes. So the problem about fit tests was real, and that
45

1 conversations with the team and the work that shared
2 services were doing on procurement as well. So it
3 wasn't a simple "shrug your shoulders, never mind", it
4 was: well, what are we doing about it? And that's
5 assurance I got from officials.

6 **Q.** By the time you left your position, were you satisfied
7 that there was a sufficient variety of types of FFP3
8 masks to fit a broader range of face sizes, shapes,
9 ethnicities and the like?

10 **A.** That was my understand, certainly. And actually, in the
11 heat of the second wave, again, I don't recall there
12 being conversations with me about the fact that there
13 was a regular shortage or a shortage of the right type
14 of mask. But I know that it was a regular point about
15 having fit tests done, particularly when you had a new
16 group of staff who needed to be redeployed into areas,
17 as well.

18 **Q.** Can I leave PPE for a moment and ask about some other
19 topics perhaps before we take our mid-morning break.

20 Can I ask you, please, about Long Covid. It was
21 known at the start of the pandemic that it was likely
22 there would be long-term effects caused by the virus.
23 Was that brought to your attention? Even if they don't
24 know the specific types of long-term consequences.

25 **A.** Yes. So at the start understanding that for most people
47

1 definitely did get raised. And it was part of the point
2 about what was being procured and actually about making
3 sure the fit test process was done properly. So people
4 have different size and shape heads, and so were these
5 masks essentially made for big blokes and not for women?
6 What about men with beards as well?

7 So there were real issues about fit tests for
8 a number of workers. Because, you know, healthcare
9 workers don't come in one simple shape or size. So the
10 fit test process mattered.

11 That also made a difference about wanting to make
12 sure that we procured items that people could safely
13 use.

14 **Q.** And what did you actually do then to ensure there was
15 a sufficient variety of FFP3 masks to fit the BAME
16 workers, to fit women, to fit people who had beards?
17 What did you do, Minister?

18 **A.** So that came up in the conversations that I had with
19 officials, not just about the stock but, as it became
20 more of an issue, about, "Look, there's an issue about
21 how these masks fit everyone". So again, with the group
22 officials that I worked with and I had responsibility
23 for, we did go through not just the concerns that were
24 being raised but about what was being done. So, you
25 know, that assurance process did take place in direct
46

1 it would be a mild and transient condition but for
2 a significant number of people, even if a small
3 proportion, it would be much more serious and the
4 recovery was uncertain for some of them. Yes, and the
5 challenge is always then about learning as you're
6 going -- and not understanding what it was going to look
7 like at the outset.

8 **Q.** Can you remember when it was you became made aware that
9 there was likely to be some long-term consequences?
10 Perhaps even -- not necessarily before it was named
11 "Long Covid" but at least the acknowledgement that there
12 would be a long-term --

13 **A.** I can't remember the exact date but I do recall having
14 conversations with the chief therapist and the
15 conversation with her about rehab. So part of this was
16 about the wider system, how it was also about how you
17 help people with rehabilitation from Covid. So it
18 wasn't called Long Covid at the time, but if you
19 obviously know it's something that affects your organs
20 and actually how do you help people, that's -- that's
21 definitely in the rehab space. So I had a conversation
22 with the chief therapist adviser and she was one of the
23 lead people on looking at what we should do to support
24 people with what has become known commonly as
25 Long Covid, with the long-term consequences.
48

1 **Q.** In your statement you say that in May 2020 you agreed
2 a national framework for rehabilitation. Does it follow
3 from what you've just said that your conversation with,
4 for example, the chief therapist happened before that
5 framework was brought into being?

6 **A.** Yes. Yes. So I definitely had a conversation with her
7 about the work that was being done to deliver
8 a framework before the framework was published. It
9 isn't the way that you learn about those things on the
10 day.

11 **Q.** Now, in Wales, the approach was to support the
12 rehabilitation of those who had had Covid-19 but were
13 still suffering from its aftereffects. It was decided
14 that that should be delivered at local level through
15 existing primary and community care services. Why was
16 that decision taken in Wales?

17 **A.** Because that seemed the most sensible way to do so,
18 given the way our system is organised and run, given the
19 way that A Healthier Wales talks about how we want to
20 run the system. So services that need to be highly
21 specialist, where people need to travel for care taking
22 place, and other services being delivered as locally as
23 possible. And actually I think this really is a space
24 that should be primary care led rather than requiring
25 people to travel to secondary care facilities, and it's

49

1 It may be coming up on screen for you as well,
2 Mr Gething. There you are.

3 **A.** Yes.

4 **Q.** Paragraph 345, you provided the update in October 2020.

5 "At that time the longer term impacts of Covid-19
6 were becoming clearer. In Wales we did not have plans
7 to develop rehabilitation centres as in England. It was
8 anticipated that it would be a relatively small number
9 overall of people recovering from Covid-19. Instead,
10 our approach was focused on providing care and support
11 as close to home as possible ..."

12 Can I ask you about the line that says it was
13 anticipated there would be a relatively small number
14 overall of people recovering. On what was that based?

15 **A.** I can't recall who gave the advice but that would have
16 been the advice on the numbers of people who were having
17 longer-term consequences, people who are still having
18 challenge from Covid after 4 and 12 weeks.

19 The thing about the number of people that had
20 Covid -- I have had Covid twice -- and it's a proportion
21 as opposed to an overall number, and it is then about
22 how you deliver the services people require. We had two
23 national centres in Wales. It would have been
24 convenient for a small number of the population and
25 everyone else would have been inconvenienced.

51

1 then about making sure we have the staff to do it and
2 the knowledge and understanding to do it as well.

3 **Q.** How did you ensure yourself that that level of care was
4 being provided through primary and community care
5 services?

6 **A.** So we have the framework we provide. It's then about
7 our understanding of what is taking place. And so, you
8 know, health boards have the responsibility to deliver
9 on the strategic choices that are made, and I was aware
10 that there were -- as we went through the pandemic there
11 were ongoing conversations about Long Covid and its
12 treatment and also about getting staff equipped to
13 understand what Long Covid was, because it was a new
14 condition for them to see as well. And I know that
15 caused some distress for people suffering with
16 Long Covid, but actually how you get this as a regular
17 part of care that is delivered as locally as possible.
18 And I expect it to be a standard part of the way primary
19 care still work today because there are people with the
20 condition today who will almost certainly get almost all
21 of their care needs delivered in primary care.

22 **Q.** That May framework I think was updated in October, and
23 can I ask that we have a look at your paragraph 345,
24 Mr Gething, in your statement.

25 It's INQ000474252_130.

50

1 And equally, if it isn't part of primary care,
2 then essentially you're managing up from primary care
3 into two specialist centres, and I don't think that
4 approach would have worked in Wales and would have been
5 wholly contrary to the method that we'd set out in
6 A Healthier Wales itself.

7 **Q.** I understand that, Mr Gething. It's not about how you
8 decided then to divide it up geographically but what was
9 the relatively small number upon which you were basing
10 the decision about how to treat and care for people with
11 Long Covid? 1,000, 10%, what was the figure in mind?

12 **A.** I can't recall without looking at the statement and
13 going back into the documents, and there's almost
14 certainly ministerial advice around this as well.

15 **Q.** All right. It's just that Long Covid data certainly
16 wasn't being collected by the ONS until April 2021. And
17 as at that stage, 56,000 people in Wales were being --
18 have certainly self-reported as suffering from
19 Long Covid. Was that the relatively small number that
20 was being envisaged in this paragraph?

21 **A.** I couldn't tell you because, without going through the
22 documents, I'd be inventing an answer and I'm very keen
23 not to do that.

24 **Q.** All right.

25 **A.** From October 2020 till now I think it's fair to say that

52

1 we have -- because we hadn't been through the second
2 wave in particular as well, we have a larger number of
3 people. It's a much more common condition of
4 significant variants that we'd have anticipated in
5 autumn 2020.

6 **Q.** All right. Well, let me ask you this. There may be
7 some, in this room even, that think that because you
8 thought it was going to be a small number that's why
9 Long Covid clinics were not set up in Wales. Is that
10 a fair comment to make or not from your perspective?

11 **A.** No. And I think if you look at the advice that
12 I received at the time and acted on, the statements
13 I gave, it was actually what's the appropriate model of
14 care to make sure that care is local, to make sure that
15 care is easily accessible. And you help them do what
16 they can do with and for themselves with support, and
17 where they need intervention or support from
18 a healthcare worker that's available as well. So it's
19 really about what you think the right model is rather
20 than wanting to underplay the importance of it.

21 **Q.** All right. You've set out the rationale for the
22 different approach in Wales. But evidence received by
23 the Inquiry suggests that the Welsh approach means that
24 patients who are referred by primary care to specialised
25 services now end up having to go and see a number of

53

1 that I gave on Long Covid in the October. And I think
2 there was a further conversation that took place in the
3 spring as we were going through. So spring 2021.

4 So it was the engagement with -- and, from my
5 perspective, the lead person that I spoke to was the
6 chief therapist adviser, because lots of support people
7 required was in the therapy space, but of course -- and
8 there was for some people a medical need as well.
9 That's the challenge you're dealing with. It's not one
10 condition, because it affects people differently, so
11 that's why you need to have a framework that takes
12 account of different need.

13 **Q.** Do you know whether there was any central reporting of
14 the number of healthcare workers that were diagnosed
15 with Long Covid?

16 **A.** It's my understanding that we didn't have that. And so
17 you have this challenge of wanting to understand what
18 happens on a whole system but you've then got to marry
19 up someone's employment record with their individual
20 patient record. You need people's permission to do
21 that. I think it would be really helpful to understand
22 the number of healthcare workers affected but that does
23 mean you've got to get permission from those people to
24 gain access to that information on an onward basis.

25 **Q.** Do you think that data should be collected by the health

55

1 specialists rather than if you had a Long Covid clinic
2 model it would be a more of a one-stop shop.

3 Did you appreciate that, in setting it up in this
4 way, there may be a need for those who have very many
5 Long Covid symptoms to now have to go and speak to very
6 many specialists?

7 **A.** Well, there's always the -- about how you learn from the
8 different models that are available, and I know that
9 Judith Paget has given observance on this as well. I'm
10 always interested in how we learn from the way we got
11 different delivery models and what that means in terms
12 of outcomes in patient experience.

13 I don't want to get drawn into trying to
14 adjudicate on the right clinical model, because whoever
15 the health secretary is in Wales will have to look at
16 that clinical evidence and listen to patient experience,
17 and I think you have evidence before you in the Inquiry
18 about the engagement did take place between medical
19 officers and the chief therapist adviser and patient
20 representatives living with Long Covid as well.

21 **Q.** Can you help how, when you were minister, were you
22 provided with information about the numbers of people
23 with Long Covid, if all?

24 **A.** So it was both in the conversations that I had about the
25 rehab framework, the focus on Long Covid, the statement

54

1 boards and then fed up to government or it should be
2 collated nationally?

3 **A.** Well, the starting challenge is you've got to agree
4 a consistent way of asking healthcare workers if they've
5 had Long Covid and then whether you want them to
6 self-report or whether you want to access their medical
7 records to understand the interventions given.

8 Employers, where there is an impact on that
9 person's ability to work, should understand that, and so
10 there may be an opportunity to do something on
11 an anonymised basis, but I still think you'd need to
12 agree that in partnership with the trade union side,
13 because there's always the risk that people fear that if
14 you're looking at how my employment has been affected by
15 a healthcare condition that it's not always for a benign
16 or a positive purpose. I say that thinking back to my
17 own time when I had a real job as a lawyer.

18 **Q.** I remember it well.

19 Let me ask you this though. It's not so much
20 about the difficulties in who is going to provide
21 permission or not but who do you say should be the body
22 responsible for collecting the data. Putting all the
23 difficulties with collecting it aside, who is going to
24 do this, Mr Gething?

25 **A.** Well, I think really health boards and trusts and

56

1 employers are the ones that are best placed to collate
 2 the data but that would almost certainly come from
 3 a national agreement or the Welsh Government on what to
 4 do broadly about collecting data but also why. So
 5 you're not just collecting data for the sake of it but
 6 why and what do we want to understand, how does that
 7 help us understand the scale of the problem, understand
 8 what to do about it, understand practical approaches to
 9 supporting people with Long Covid, and to keep them in
 10 the workforce, which I think would be largely the
 11 objective. So I think there would be value in doing
 12 that, but you need to ask yourself some of those
 13 questions first otherwise you'll end up with potentially
 14 seven different approaches.

15 **MS CAREY:** Mr Gething, that maybe takes us conveniently to
 16 our mid-morning break.

17 **LADY HALLETT:** It is. I shall return at 11.30.

18 **MS CAREY:** Thank you, my Lady.

19 (11.14 am)

20 (A short break)

21 (11.30 am)

22 **LADY HALLETT:** Ms Carey.

23 **MS CAREY:** Thank you, my Lady.

24 Mr Gething, can you hear me all right?

25 **A.** I can hear you fine, thank you.

57

1 others, but equipment that had been pre-ordered by
 2 Public Health Wales hadn't always arrived and we also
 3 had issues with some of the reagents as well. So
 4 I think -- without the 5,000, I think we were far short,
 5 but I haven't got that in front of me.

6 **Q.** All right. So you don't know what the position was at
 7 1 April, whether you had 1,000, 1,500, 2,000, what you
 8 had by 7 April or what you had by the end of April?

9 **A.** I can't tell you offhand but there will be figures
 10 available about the amount of testing that we had and
 11 how it was deployed.

12 **Q.** All right.

13 I ask about testing because clearly it has
 14 an impact or an effect on nosocomial transmission and
 15 how one tries to prevent acquiring hospital-acquired
 16 infection. In Wales, is this right, that the Nosocomial
 17 Transmission Group was established on 19 May of 2020,
 18 and you say in your statement that that was a group that
 19 did not report to ministers.

20 Why did that group not report to ministers?

21 **A.** The group didn't formally report to ministers in the
 22 chain, as it were, because the chairs and co-chairs
 23 that -- the Deputy Chief Medical Officer and the chief
 24 nurse were part of a senior group of officials, and so
 25 actually our understanding of what was happening at the

59

1 **Q.** Can I turn to nosocomial infections and the testing of
 2 the healthcare workers, and can I ask you this. At your
 3 paragraph 295 you set out that at the start of the
 4 pandemic, on 21 March of 2020, Wales set an ambition of
 5 6,000 tests a day by 1 April, 8,000 a week later, by
 6 7 April, and 9,000 by the end of April.

7 Can I ask you, was that a target ambition to cover
 8 tests for patients and healthcare workers?

9 **A.** Yeah, it was to use the tests in accordance with what we
 10 thought the value of testing was at that point in time.

11 So symptomatic patients and workers, yes.

12 **Q.** Were any of those targets met?

13 **A.** No. And I think I explain it in the following paragraph
 14 about the unfortunate business with Roche and the way
 15 they engaged with us, Wales and England.

16 **Q.** Yes, you do. It's set out at your paragraph 296,
 17 Mr Gething.

18 But I think in fact by mid-April, 20 April, the
 19 9,000 testing target for the end of that month was
 20 abandoned as well.

21 Do you know how far short Wales had fallen as at
 22 1 April, 7 April and the end of April?

23 **A.** Well, apart from the 5,000 that we thought we'd get,
 24 I think we also had some issues with supply chain,
 25 because -- I'm not sure if this is in my statement or in

58

1 time -- I had reports both from the Chief Scientific
 2 Adviser for Health, the TUC and TAG group, the chief
 3 medical adviser and the chief exec directly to me. So
 4 nosocomial transmission was a real concern that was
 5 readily discussed with me and it was one of the Chief
 6 Medical Officer's concerns about the estate that we had
 7 and about the fact that it didn't make for good
 8 infection prevention and control.

9 **Q.** There was evidence, I think, of nosocomial transmission
 10 certainly in one of the health boards from as far back
 11 as March 2020.

12 Can you help with why it was that the group wasn't
 13 set up then until 19 May 2020?

14 **A.** So, nosocomial transmission is a regular feature of
 15 healthcare work and the fact that people can get
 16 additional conditions whilst they're undertaking
 17 healthcare for something different. And so, given we
 18 knew it was an infectious disease -- an infectious
 19 condition, I understood there would be some nosocomial
 20 infection.

21 And the evidence about what was taking place in
 22 March wasn't really revealed until later. I think
 23 there's a document in evidence about a study that showed
 24 that there was a cluster in Aneurin Bevan that
 25 (inaudible) driven by nosocomial transmission. But the

60

1 challenge is how you get people to adhere to good IPC
2 practice, how you have PPE to help with that and how the
3 estate helps or hinders with that as well.

4 **Q.** I understand that. In fact it was Public Health Wales
5 that produced a report on 31 March which certainly
6 showed there were outbreaks in Aneurin Bevan, I think,
7 that was consistent with nosocomial transmission.

8 It's not the fact that everyone acknowledges there
9 may be nosocomial transmission, the question is why it
10 took so long to set up the group, given that it is
11 obvious to all there will be at least some
12 healthcare-acquired infection?

13 **A.** Because this is part of how a health service operates,
14 and there should be a focus on good IPC practice as
15 a regular part of healthcare.

16 So pre-pandemic it was one of the things that
17 I spoke to chairs and others about, about the levels of
18 healthcare-acquired infection that took place. And so
19 there is something about -- it's about practice, it's
20 about how rigorous that is. And, you know, not just, if
21 you're the minister, going on a visit about making sure
22 you roll your sleeves and tuck your tie in but actually
23 what happens as a matter of course. So you don't see,
24 you know, old pictures of, you know, consultants with
25 long sleeves and a tie wound around leaning over people.

61

1 So, look, I'm perfectly prepared to accept that --
2 even in the moment and at the time, could we have acted
3 earlier? Quite possibly. For the future, it is one of
4 the things that I think is worth doing, about saying:
5 make sure if we have an infectious disease in a pandemic
6 that nosocomial transmission is an early priority, with
7 a rigorous reinforcement of why good IPC practice is
8 essential.

9 **Q.** All right. Can we have a look at some of the figures,
10 please.

11 Can I ask that be put on screen INQ000396261.

12 This is, in fact, a briefing I think provided by
13 the Nosocomial Transmission Group on
14 15 November of 2020, and it sets out not just hospitals
15 but care homes but I'm obviously just going to focus for
16 today's purposes on hospitals.

17 As at November 2020, rates there are increasing as
18 community transmission has increased. We can see there
19 during the last week until 8 November there were
20 210 cases of probable or definite acquired Covid, which
21 represents 3% of all cases diagnosed but 50% of all
22 cases diagnosed in hospitals.

23 And then set out per board the number of cases and
24 the percentages. We can see there Cwm Taf with the
25 highest number, followed by Swansea Bay.

63

1 Actually, it's the (*inaudible-cough*) that things matter.

2 The group was there to give a focus to what was
3 happening, to try to draw together what was taking place
4 nationally. So it was a response to what was taking
5 place in front of us.

6 **Q.** All right. I suppose the question is, really, do you
7 think that response was too slow? Given that you knew
8 at the end of the March that it was happening, that it
9 inevitably always happens, why not set up the group
10 sooner?

11 **A.** Because the expectation is that this is what happens
12 normally and you should have -- as in normally you
13 should have people getting on top of nosocomial
14 transmission. And when you see it isn't, it's then what
15 you do about it. There's the normal line management,
16 whether that's the CMO or DCMO talking to medical
17 directors, the chief nurse talking to nurse directors,
18 and then actually, as that didn't -- didn't deliver,
19 this group was set up.

20 I think it's fair to ask the question about how
21 soon is it set up in a future pandemic, how soon do you
22 actually reiterate the need for fairly rigorous
23 adherence to good IPC practice and the fact that there
24 are consequences for healthcare workers and patients if
25 you don't.

62

1 And indeed, if one goes down the page a little
2 bit, reference to the Public Health Wales data
3 indicating how many patients were Covid positive in
4 hospitals, how many beds were occupied by people who
5 didn't have Covid:

6 "... around 3.5% are being infected each week by
7 COVID-19 within the hospital environment."

8 That's presumably across the whole of Wales.

9 And I think it's this:

10 "The evidence suggests that properly used [PPE]
11 limits transmission between staff and patients but
12 that transmission is occurring between ...

13 "Transmission between staff is often seen as
14 a result of a lack of social distancing in
15 non-clinical areas. Although staff should test
16 positive at a similar rate to their local community,
17 one Health Board ... found 24% of staff were positive
18 despite an approximately 1% community prevalence."

19 When you received this briefing, what steps, if
20 any, did you take to try to ensure that IPC measures
21 were being properly enforced, that there was properly
22 used PPE, that you were limiting, insofar as you were
23 able, Mr Gething, to ensure there was social distancing
24 in non-clinical areas?

25 **A.** So I can't recall definitively what I did in response to

64

1 this particular briefing but I do recall that about this
 2 time is when we were going to further iterations of what
 3 we would do in the testing, testing around outbreaks,
 4 whether at care homes or hospitals, and we knew that we
 5 had outbreaks around hospitals where we had undertaken
 6 wider testing, and the testing infrastructure was
 7 becoming more -- more portable, because this is just on
 8 the cusp of lateral flow devices. So I think we'd used
 9 lateral flow devices around potential outbreaks as well.
 10 So this was around, again, the reiteration of why it's
 11 important.

12 And I think the transition between staff and the
 13 lack of social distancing in non-clinical areas, that's
 14 really difficult because -- and I wouldn't want this to
 15 be seen as a staff not being interested about this but
 16 actually it's the pressure they're under and it's what
 17 happens when they feel a sense of relief at not being in
 18 a clinical area. It's a fairly human response. But
 19 there are consequences -- and that's why the rigour in
 20 not doing this really matters.

21 So I recall having conversations with the DCMO and
 22 the chief nurse about nosocomial transmissions, had
 23 reports they were bringing back from this group and what
 24 they were looking to do to try to make sure that our
 25 whole system responded.

65

1 service to do.

2 And the fact that this data wasn't kept secret in
 3 that sense, health boards knew they had problems, and in
 4 fact the way Test, Trace, Protect was deploying testing
 5 resources about outbreaks, again every time was
 6 reiterating: there is a reason why this is happening,
 7 protect yourself and the people you care for when it
 8 comes to the service.

9 But this is very, very uncomfortable, in the
 10 pandemic and now, about understanding that infections on
 11 a hospital estate were a real factor in the harm that
 12 was caused.

13 **Q.** I think you have seen that there was a second briefing
 14 by the Nosocomial Transmission Group in February 2021
 15 which showed a position that had worsened from the
 16 November 2020, with effectively higher rates of
 17 nosocomial infection.

18 Did you put into place any steps between wave 1
 19 and wave 2 to try to reduce the amount of nosocomial
 20 transmission, and if so what were they?

21 **A.** I can't give you a documentary review now without
 22 pointing to a particular document. But I am clear that
 23 the Nosocomial Transmission Group directly impacted on
 24 conversations with chief execs and chairs about what was
 25 happening. And I'm pretty sure it was part of the

67

1 I can't recall for you whether I had
 2 a conversation directly with this about chairs but
 3 I know that chairs of health boards raised it themselves
 4 about things that they were concerned about throughout
 5 the pandemic.

6 **Q.** May I ask you this. A number of times this morning
 7 you've spoken about the conversations you were having,
 8 and you've told us about how it's a smaller community in
 9 Wales and so perhaps doesn't have the formality that one
 10 might otherwise expect, but how are these conversations
 11 recorded so people know what it is you've told them that
 12 you want done?

13 **A.** So if I'm having a meeting with the chief nurse, there
 14 will be a brief minute. There'll be a minute of the
 15 meeting. It won't capture chapter and verse about
 16 what's being done. There are minutes taken of meetings
 17 with chairs of health boards. There are -- the
 18 conversations with trade unions are more about us
 19 agreeing action points at the end of that rather than
 20 there being an exhaustive minute of it. So, you know,
 21 in the -- in the significant number of documents there
 22 should be documents that point out when those
 23 conversations are taking place, not just the briefings
 24 delivered but also should -- you've got to see practice
 25 from those service leaders about what they're asking the

66

1 operating framework, as well, about how people were
 2 supposed to be dealing with where we were. And it's not
 3 a surprise to me that transmission increased by the time
 4 we got to February because we then had a more
 5 transmissible variant in circulation across the great
 6 majority of Wales. So even if there had been
 7 an improvement in practice, actually, Covid was even
 8 better at spreading.

9 **Q.** Yes, everyone understands that that variant was more
 10 transmissible. But that might be seen by some to be
 11 an easy excuse to explain away what, on one view, is
 12 a worsening position from what was already bad
 13 in November 2020, to incredibly bad by February 2021.
 14 Was there anything done to try and establish whether it
 15 was the sheer transmissibility, or whether IPC had
 16 improved, or worsened? Do you see the point I'm making?

17 **A.** Yeah, and so my understanding is that the Nosocomial
 18 Transmission Group and its direct engagement with the
 19 service and the leadership around that is what should
 20 have made the difference. And, in particular, nurse
 21 directors have a lead role on IPC and their health
 22 boards, around the practice and the culture developed
 23 around it. The challenge is when you recognise
 24 something has gone wrong, how you then get back to it,
 25 and I know it is, again, one of the points, I think, of

68

1 learning for the future about the importance of IPC
2 because there's no sugar coating the fact that the
3 position worsened and real harm was caused. So I'm not
4 trying to avoid that; it's an explanation rather than
5 an excuse.

6 **Q.** A slightly different topic but related. Did you
7 consider or receive any information about the impact of
8 nosocomial transmission on patients who were clinically
9 more vulnerable given that those who are clinically
10 vulnerable are more likely to need to go into healthcare
11 settings to receive their ongoing treatment? Was that
12 brought to your attention at all, Mr Gething?

13 **A.** I don't think I had a specific report about nosocomial
14 transmission and the clinically vulnerable but I always
15 understood that people with greater comorbidities that
16 we saw in our hospital estate in the second wave in
17 particular and in even larger numbers and the fact that
18 hospitals were fuller at the start of it because we'd
19 restarted some activity, meant that there was a greater
20 potential for harm.

21 **Q.** In March 2021 there was a framework for Covid testing of
22 patients in hospitals in Wales. Do you think that that
23 framework was published too late, given the rates of
24 nosocomial infection that we've just looked at?

25 **A.** Well, by that point we'd been testing patients on entry

69

1 **Q.** Given that you lived through it as minister, do you
2 consider there is a need for more steps to improve
3 ventilation within the NHS Wales estate as a mitigation
4 against future pandemics?

5 **A.** Yes, but the starting point is what does the estate look
6 like now and what will it look like in the future,
7 because, actually, it would be a better answer to have
8 a new premises as the main DGH for West Wales rather
9 than retrofitting on to old buildings. But if you can't
10 deliver that entirely new estate then of course you need
11 to take the steps and the measures that you can do.

12 **Q.** All right. DGH, district general hospital, is that what
13 you meant?

14 **A.** District general hospital.

15 **Q.** Finally this, please, on nosocomial. Were there any
16 investigations set up in your time to investigate
17 cluster outbreaks in hospitals?

18 **A.** Yes, so I recall, for example, an outbreak in Wrexham
19 where there was an investigation about why it had
20 happened and how, as well as the testing for a wider
21 group of staff as well. So -- and that approach was
22 being taken where outbreaks took place, but the Wrexham
23 example is one that sticks in my mind.

24 **Q.** May I, in the few minutes I have with you, Mr Gething,
25 go through a number of discrete topics. The fact that

71

1 into hospitals and during their time in hospital as
2 well. The framework draws together both the updated
3 evidence but also practice that has already been taking
4 place, and that was important both for entry as well as
5 treatment as well as discharge. Discharge had been
6 a real issue throughout the pandemic, and having the
7 confidence of people who no longer had Covid or were no
8 longer infectious before they could be moved.

9 So the framework in March drew together practice
10 that had already been taking place as opposed to
11 an entirely novel approach where no testing had been
12 taking place before then.

13 **Q.** You've mentioned a number of times the hospital estate
14 in Wales. Were -- did you receive any requests for
15 funding to increase ventilation, particularly for
16 example HEPA filters or other portable ventilation, to
17 try and assist with that aspect of IPC?

18 **A.** I can't recall if I did or if I cleared ministerial
19 advices on that basis but I do know that health boards
20 did manage to install additional ventilation. Again,
21 I know that in Phil Kloer's evidence he points out that
22 in Glangwili you couldn't open windows all the way
23 open -- and there's a good reason for that, but they did
24 manage to acquire additional mechanical ventilation to
25 help with that.

70

1 I am dealing with it quickly should not be taken to
2 diminish its importance. It's just there may be other
3 questions that are asked about it around the room.

4 Can I start with shielding. In Wales, we know
5 that, obviously, shielding was brought in in March 2020
6 until at least 15 June but, in fact, you did not pause
7 it, I think, on 31 July as other countries did, but
8 extended it to 16 August 2020; is that correct?

9 **A.** Well, actually, we maintained at the time we'd already
10 announced. If we'd ended it on 31 July we would have
11 had to bring the end of shielding forward. We had
12 already told people we'd shield to that point in August
13 and I've set that out in my evidence.

14 **Q.** I think you said you didn't pause it earlier but
15 extended it to 16 August to give, in part, people time
16 to prepare as a result of concerns raised by the
17 Disability Equality Forum and because you were concerned
18 that people felt, to use your words, abandoned not
19 liberated.

20 **A.** People were fearful and if we told them everything is
21 fine, go out and about but be careful, I think we'd have
22 had a real challenge if we'd have said we're ending
23 shielding early, because that would have been the
24 message. And, again, looking in hindsight, I think how
25 you manage an intervention like shielding, how you tell

72

1 people "You are particularly vulnerable so take extra
2 care", and then how you bring people out of shielding is
3 actually really difficult in terms of managing human
4 behaviour. Because, you know, at that point I thought
5 the summer was going to be as good as it was going to
6 get for a while. I didn't quite anticipate the speed of
7 the second wave in the autumn into the winter. But
8 again, it's one of those decisions where there is harm
9 whichever way you look at it, as well as potential
10 benefit.

11 **Q.** How were the concerns about feeling abandoned,
12 liberated, people being worried about how disability
13 groups would be able to manage the transition, how were
14 they raised with you, Mr Gething, through what fora?

15 **A.** So there was a direct conversation with Jane Hutt who
16 was a deputy minister dealing with the sector at the
17 time, I think the Chief Medical Officer attended as
18 well. I even had those conversations, direct reports
19 back around how people felt, and so I had looked at what
20 the feedback we were getting and how you help people to
21 feel that they're being supported, that's both with the
22 volunteers who were in place by then. But the food
23 boxes weren't just, I think, eventually about having
24 a supply, but it's also contact with other people.

25 And I had to go and see my own mother. And so

73

1 quality of ethnicity data has resulted in poor health
2 decisions, and BAME communities face a higher risk of
3 catching and dying from the disease. Also captured are
4 the experiences of racism from specific BAME groups
5 exacerbated by Covid-19 ..."

6 Did you -- do you agree that going into the
7 pandemic there was a lack of or poor quality of
8 ethnicity data?

9 **A.** Yes. So the data fields weren't always completed or
10 pursued. We understood generally what our health
11 service workforce looked like with a higher degree of
12 black and brown people within it than the wider
13 population, and actually people within our communities.
14 None of what this part of the report says was a surprise
15 to me at all.

16 **Q.** With that in mind, why was the data, though -- if it's
17 not surprising, why was the data so poor, why haven't
18 you and other ministers done something to improve the
19 quality of the data?

20 **A.** Well, the quality of the data requires you to invest in
21 it and it requires there to be a response, we had staff
22 alongside understanding why the data matters and what
23 it's going to do. So we set out a series of responses,
24 I think I have covered these in some detail in my
25 statement, about what we were doing to try to improve

75

1 actually me delivering her shopping meant she saw
2 someone and, you know, regularly having to tell her
3 "I can't come in and I can't give you a hug" was
4 difficult, but I actually got to talk to her. So part
5 of that was about the contact people had and the
6 connection and at the same time not wanting to feel that
7 people are going to be made vulnerable if they have too
8 much contact with other people. If my mother had got
9 Covid, it would almost certainly have been from me,
10 because for a substantial period of time, as well as my
11 duties, I was the only person who was going to visit.

12 **Q.** May I ask you about data and, in particular, can I ask
13 you about ethnicity data in Wales.

14 I think you know from the work of the subgroup of
15 the BAME Covid-19 advisory group that there was
16 a disproportionate impact on minority ethnic
17 communities.

18 Could we have up on screen, please,
19 INQ000227599_2.

20 It's the front page, Mr Gething, of a report from
21 the BAME Covid-19 Socioeconomic Subgroup from June 2020.

22 And if we could just look at the "Racial
23 Inequalities" section:

24 "The report finds that race inequalities exist in
25 Wales. In light of Covid-19, the lack of or poor

74

1 the data, and it's also why the risk tool was developed,
2 reflective of the fact that ethnicity was a factor in
3 the level of your risk as well. Trying to capture those
4 different fields of data, isn't just about a celebration
5 of diversity in the service, it's practical as well, and
6 that's why in responses we finally had some --
7 a practical shift behind -- there's a real practical
8 reason to do this in amongst all the other priorities
9 that the service has to deliver.

10 **Q.** Can I go on in this document to page 8, please, because
11 the recommendation of the subgroup was this. To:

12 "Take immediate action to improve the quality of
13 recording of ethnicity data in the NHS and across health
14 and social care services to ensure parity of BAME data
15 collection, monitoring and reporting."

16 What immediate action did you take as minister,
17 Mr Gething?

18 **A.** So this was part of the response I set out in my
19 statement in 164, paragraph 164, I go through it in some
20 detail about not just what was happening in the NHS but
21 across the government. So there is more data that's
22 been collected. There are still gaps and there are
23 further steps that are being taken to understand how we
24 improve that data on the workforce.

25 So it's not as simple as you flick a switch and

76

1 then two weeks later all the data exists. And frankly,
2 if we had tried to do that in the middle of the pandemic
3 I think we would have got a pretty robust response.

4 But it is about understanding and improving the
5 data we have for a purpose. And like I said, that
6 purpose is not just borne out in this but it's about who
7 you recruit, who you retain, where they are in the
8 service. Some of that I'm aware of from before my time
9 in public life as well as the reality of where we still
10 are now.

11 So we're in a better place than we were at the
12 time the report was published but there's a good deal
13 further to go.

14 **Q.** Do you feel the paucity or lack of the data available to
15 you for ethnicity affected any of the decisions that you
16 took whilst you were minister or had there been better
17 data you might have taken a different decision?

18 **A.** I think once the data became aware that different ethnic
19 groups had a higher risk to harm from Covid, if we knew
20 that earlier then we might have made other choices.
21 When we had the risk tool, it was helpful. It provoked
22 individual conversations about what took place. So some
23 of this was about ethnicity data. But some of it also
24 was about occupational segregation as well. So the fact
25 that being a taxi driver or a bus driver meant you had

77

1 us about how the views of the frontline via your
2 conversations with the BMA, the royal colleges, alike,
3 were helpful to you. I think you are aware there was
4 a nursing survey done in November 2020 where 34% of
5 staff felt undervalued by the Welsh Government which was
6 the highest percentage across the UK, and that 74% had
7 seen increase in stress levels. When you were made
8 aware of the feelings of undervalue by the nurses, what
9 steps did you take to try and mitigate or make less bad,
10 I should say, the undervaluing that they were feeling?

11 **A.** So I discussed the report with the chief nurse. I'd
12 been caught off-guard by the report because for all of
13 the regular conversations we had, I learnt about this
14 survey when the press release came out. And so actually
15 then, understanding what you do to try to understand why
16 people feel less valued from the headline figure was
17 actually, you know, I placed enormous store on what our
18 staff were doing.

19 So from my own position, I'd always valued our
20 staff because you can't run the service without them and
21 I valued that because of my own interaction as
22 a patient.

23 So it's how you get over and understand that
24 people feel bruised and not recognised. Sometimes
25 that's through pay and reward. A lot of the time it's

79

1 a higher likelihood of getting Covid than being
2 a teacher was evident from the data, but also some of
3 that also overlaid with the ethnicity data as well.

4 So it's about the wider population in addition to
5 what we're doing in the service. But I couldn't point
6 to an individual example that if we had had better data
7 in February 2020 we'd have made different choices
8 because actually the learning on the differential impact
9 for ethnic groups came during the first wave not
10 before it.

11 **Q.** In relation to different data, was any department or
12 organisation that you are aware of monitoring the deaths
13 of healthcare workers from Covid in Wales?

14 **A.** I saw figures on deaths of healthcare workers at various
15 points in time. So employing organisations were aware,
16 of course, and they reported those deaths. And I can't
17 remember if it was Public Health Wales or if it was
18 through health boards and trusts themselves. But, yes,
19 I was aware that healthcare workers lost their lives and
20 I was aware of the impact that had.

21 I know sometimes large organisations can seem
22 remote, but in my dealings with chairs I can tell you
23 they really were affected when members of staff lost
24 their lives.

25 **Q.** A different effect on healthcare workers. You've told

78

1 through what you say as well. But I know that the chief
2 nurse had conversations with all the nursing directors
3 and it came up again when I had those conversations with
4 the trade union groups as well.

5 **Q.** Three short topics I must cover.

6 DNACPRs, Mr Gething. At any stage of the pandemic
7 whilst you were minister, were you made aware of
8 concerns about blanket or inappropriate DNACPRs being
9 imposed and, if so, what did you do in response to those
10 concerns being raised?

11 **A.** Yes, so the Older People's Commissioner raised general
12 concerns about DNACPRs. She didn't give me any specific
13 examples but we did have certainly an instance where
14 a practice had written to people, I think suggesting
15 DNACPRs and that just wasn't appropriate or in line with
16 policy. So we dealt with that not just with the
17 practice and the board but we did then re-issue the
18 guidance and make clear the guidance that had come
19 through the Ethical Advisory Group, and I think the CMO
20 and the CNO wrote out to health boards, medical
21 directors and nurses, but part of the challenge is in
22 how you get over to people the pandemic doesn't change
23 DNACPRs, there should be an individual conversation
24 about that with the person, with their family about what
25 this means, and it was never appropriate to have

80

1 a blanket policy and I know some disability groups were
2 concerned as well.

3 So I think we re-issued and reiterated the
4 guidance on several occasions and I certainly publicly
5 dealt with the issue with the general practice that was
6 brought to my attention.

7 **Q.** Visiting restrictions, please. In your statement you
8 set out that you were very sympathetic to those affected
9 by visiting restrictions, particularly within the
10 maternity setting.

11 Looking back now, Mr Gething, do you consider that
12 the visiting restrictions struck the right balance
13 between the benefits of visits to patients and their
14 families and reducing the risk of visits bringing in
15 infection?

16 **A.** In hindsight I think that we might have done more to
17 enable visits. In the maternity field having whoever
18 your birth partner is, whether it's the other half of
19 a woman giving birth, or not, I think the support for
20 the women giving birth but also -- and I think about
21 this because there was such -- I think about my own life
22 and becoming a parent and if I had been a new parent in
23 the pandemic and not able to go to the scans, you can't
24 get that back, and so there's the challenge of how you
25 then have enough safeguarding place to make sure that

81

1 it's a scan or whether it's the ability to go into
2 a neonatal ward if babies are particularly ill. So
3 I think there is something about understanding and
4 seeing them as a unit in the way that we did, late in
5 the pandemic, see households as a unit. And so if you
6 see it in those terms, then actually is the risk being
7 increased to an unacceptable level if both of those
8 people come to scans? And I think that's a good example
9 of where you can say the balance should be in favour of
10 both those people attending whether it's neonatal care
11 or scans or actually giving birth.

12 **Q.** It means you need to have more PPE in your stockpile
13 going into a pandemic, doesn't it?

14 **A.** It certainly would and that is a separate learning
15 lesson for a whole host of reasons, and this is one of
16 them.

17 **Q.** All right. A final discrete topic is this. I think
18 you've been provided with a copy of the "Locked out:
19 liberating disabled people's lives and rights" report,
20 which although published in July 2021, looked back over
21 your time as minister, and in that report disabled
22 people certainly reported that their access to going to
23 medical treatment and health services was severely
24 disrupted and lots of disabled people reported they were
25 either in receipt of care or awaiting care and felt

83

1 you're doing all those things in a way that matters and,
2 in particular, people with cognitive impairments, and
3 visiting is a part how to keep that person well. So our
4 ability to scale up testing to make that safe but to
5 appreciate the harm being done if people can't go there
6 and to balance that with the very real fear that staff
7 had about additional transmission.

8 So there is always a balance to be struck but
9 I think the chief nurse at the time has reflected on
10 this and I think it's definitely a learning point for
11 the future about how you strike that balance and how you
12 explain it and then how you review the evidence over the
13 different harms that are being done in practice.

14 **Q.** You said there "with hindsight we could have done more".
15 Can you think of a practical suggestion of what more
16 could be done absent testing being available?

17 **A.** Well, we could have used PPE as control measures but
18 you're still dealing with risk and it's the balance of
19 risk as opposed to saying there was no risk. Having --
20 in particular, if a couple live together and one part of
21 that couple goes in for the scan, there's a fair
22 argument about whether actually you're reducing the risk
23 significantly by only having that person in when they
24 have direct contact with the person they live with.

25 So I think there is something about that, whether

82

1 their health had worsened.

2 During your time as minister, was any specific
3 work done by you or the department to ensure disabled
4 people could access healthcare?

5 **A.** Yeah, I think the challenge is that disabled people
6 covers a wide range of people, people with learning
7 disability, people with physical disability, and many of
8 those are core participants, patients in the service.
9 And so, actually, that group were affected as was the
10 whole population. I think the challenge is our
11 understanding about, for example, how you make sure
12 people are still listened to about their care, how they
13 access that care when lots went to remote services,
14 either telephone or on screen, but the fact that people
15 have capacity to make choices as well.

16 So I understood why people were concerned about
17 that and the regular reports we had from both the Older
18 People's Commissioner, the Human Rights Commissioner,
19 and, indeed, the disability equality groups that we
20 engage with as well.

21 So there are a range of things we tried to improve
22 as we went through the pandemic but I think, looking
23 back, it's quite important to learn from what you think
24 you got right and not and how that affects current and
25 future practice.

84

1 Q. That brings me on to my final question, please,
 2 Mr Gething. If you could make one recommendation to
 3 her Ladyship for how to improve the healthcare system's
 4 response in Wales, beyond having more tests available at
 5 the beginning and more PPE in your stockpile, what would
 6 your recommendation to her Ladyship be?
 7 A. I think you'd also have to just take out finance,
 8 because if you want to improve your estate, you have to
 9 spend lots of money on it. I actually think that
 10 I've covered this lots in evidence but I think a lot of
 11 it is how you make your sure system is as collaborative
 12 and as open as possible so you can listen to the real
 13 experience of staff and the challenge is how you manage
 14 that. And you can't say to tens of thousands of staff,
 15 ring the minister up. But it is around culture in the
 16 service and I think that really matters. Because you're
 17 asking staff to put themselves in harm's way and so how
 18 you listen to them and value them I think really does
 19 matter.
 20 MS CAREY: Mr Gething, they are all the questions I ask but
 21 I think we're now going to turn to some questions from
 22 the core participants.
 23 LADY HALLETT: Mr Weatherby.
 24 Questions from MR WEATHERBY KC
 25 MR WEATHERBY: Good afternoon, Mr Gething, can you see and
 85

1 of shielding and why you weren't? Did you try to come
 2 to an arrangement which would have covered -- persuaded
 3 the other -- the UK Government in particular to see the
 4 point of view that you'd accepted?
 5 A. Well, the problem is that this was an example of where
 6 a decision is made and then announced or, essentially,
 7 given to devolved governments. And you either decide
 8 that there's more benefit in doing the same or you say,
 9 actually, I can't and I won't do that. If I decided to
 10 go ahead with pausing shielding, essentially two weeks
 11 earlier than had already been communicated, without
 12 having a conversation with my own stakeholders in Wales,
 13 I think that would have led to a lack of trust. So
 14 there's more than one thing. The decision isn't just
 15 a shielding choice in itself, it's more than that, and
 16 I've expressed before some frustration about the way
 17 that some UK Government choices for England were made
 18 without there being a prior discussion with all four
 19 nations.
 20 Q. But that was my question. Did you actually have those
 21 discussions with the UK Government or did you just --
 22 were you just frustrated that they hadn't come to you
 23 first?
 24 A. Well, I was frustrated and it was certainly part of the
 25 health minister's call but once the UK Government
 87

1 hear me?
 2 A. I can indeed.
 3 Q. I'm asking you a short number of questions on behalf of
 4 Covid-19 Bereaved Families for Justice UK which includes
 5 quite a number of families from Wales, and the two
 6 topics I'm going to ask you about have been dealt with
 7 to some degree by Ms Carey already, so that will allow
 8 me to go very quickly.
 9 First of all, shielding. Ms Carey was asking you
 10 about the position of shielding in the middle of 2020.
 11 And you deal with it in your statement at paragraph 138.
 12 And you were explaining that although shielding was
 13 paused elsewhere, at 31 July you continued it in Wales
 14 until mid-August and you gave us the reasons why. And
 15 that was that you you'd been approached by the
 16 Disability Equality Forum and there had been concerns
 17 about the abrupt stopping of shielding would leave
 18 people feeling abandoned. That's right, isn't it?
 19 A. Correct.
 20 Q. The question I have is that you note in your statement
 21 that the ending of shielding elsewhere in the UK on
 22 31 July and the position in Wales may have caused
 23 confusion, and just this. Did you raise this with the
 24 UK Government or other devolved administrations and the
 25 concerns that you in Wales had about the abrupt stopping
 86

1 decided to do that, they never changed their mind once
 2 they had announced something, if a devolved government
 3 had said: we don't think that's the right thing to do.
 4 Q. The second and final topic, PPE. And again, Ms Carey
 5 has certainly touched on this. Ms Carey put to you the
 6 hospital consultant's email from 24 March, the chaos
 7 email, where the consultant was raising with you the
 8 lack of protection, and lack of masks in particular for
 9 nurses. And then paragraph 317 of your statement you
 10 assert that on 21 April you publicly noted that Wales
 11 only had enough left in the stockpile for a few days and
 12 you also indicate that there was an underestimation of
 13 how quick PPE would be used, how rapidly supply chains
 14 would fail and that some of the existing stockpile was
 15 not fit for purpose.
 16 Looking back on it, given what you said earlier
 17 this morning about what we saw on our screens from Italy
 18 in February, do you think this is something you should
 19 have seen coming and you should have addressed the lack
 20 of PPE and the distribution issues that you've touched
 21 upon, do you think you should have seen this coming
 22 before it was raised by the consultant and before it
 23 became -- the shortage actually became apparent on
 24 21 April?
 25 A. I think there's a number of different things. The first
 88

1 is that, actually, even with the example of northern
2 Italy we still thought we had a pandemic stock that
3 would last for longer than it did, and until we were
4 genuinely having to deal with it directly it was hard to
5 see that that stock wouldn't last as long as it did or,
6 indeed, that the supply lines would collapse in the way
7 that they did, and by the time we got to March,
8 you know, it was then the contracts simply weren't being
9 fulfilled and that gave us a real problem, and with
10 respect, I don't see how we could at that time have
11 anticipated all of that.

12 The second point I think is that by the time
13 I made the statement in April, I'd seen what was
14 happening, I was able to indicate we'd come within days
15 of running out of some of the items --

16 **Q.** Yes.

17 **A.** -- but we'd also managed to get mutual aid and more
18 stock in, I was getting over that PPE was a real
19 resource that had to be properly used to protect people
20 and it was something that the Welsh Government was
21 taking a significant amount of interest in.

22 **Q.** Yes. But following what you saw on your screens
23 in February, did you actually take any measures in
24 between February and April when you made this
25 announcement in terms of ramping up PPE or checking the

89

1 I suddenly get interested in PPE. I had taken an
2 interest in it because of the reality of how serious
3 an issue it was.

4 **Q.** Final point. In Wales the procurement of PPE was a dual
5 approach where you had the four nations basis where the
6 UK acted as the lead purchaser and you had a Wales-based
7 NHS Share Services partnership I think.

8 **A.** Correct.

9 **Q.** How did you ensure, as minister, that those two parallel
10 systems worked together given what you said about the
11 relationship with the UK Government?

12 **A.** So PPE was a significant part of our conversations as
13 ministers across four nations, about where it was and,
14 frankly, whether there was enough trust that the UK was
15 procuring on behalf of the UK, that fair shares would be
16 properly delivered. I don't think the UK Government's
17 procurement mission stood up as well as the one that we
18 were responsible for. Others will have their views, but
19 we eventually managed to not just secure supply lines
20 but we provided mutual aid to other parts of the UK in
21 more significant number, and it mattered because we had
22 to procure not just for the health service but also for
23 social care and at the early stages not everyone at a
24 local level trusted the NHS to get that in because so
25 many local supply lines were collapsing.

91

1 PPE you had or checking the distribution measures that
2 you had in place?

3 **A.** Yes, and I think I've been through this with Miss Carey
4 and it's in my statement. So I had had conversations
5 with the senior officials that I worked with about the
6 amount of PPE that we had, the run rate we had on that,
7 when our new supplies were coming -- there's the
8 infamous incident of tracking a plane that came in and
9 landed in Cardiff airport and I think they were supplies
10 from China and Cambodia that we got that were essential
11 to us getting PPE. The failure of a flight in Turkey
12 the UK Government said it had procured. And actually,
13 how we managed was a real concern and a real part of my
14 activity as the minister as well as making sure that we
15 got stuff that was usable.

16 **Q.** Yes, but --

17 **A.** So it was a significant part of my time, energy and
18 effort.

19 **Q.** But that was going forward, presumably from April rather
20 than prior to April, those measures you've just talked
21 about?

22 **A.** No, it came from a conversation, not just the email
23 24 March, but actually it's a growing concern and
24 something that takes up my time through the end of March
25 and April. It isn't just at the end of April that

90

1 So it was not a straightforward or an easy
2 conversation to have either in Wales or with other parts
3 of the UK but we eventually reached a position where
4 there was enough trust between different governments
5 and, crucially, enough supply.

6 **MR WEATHERBY:** Yes.

7 Thank you very much. Those are my questions.

8 **LADY HALLETT:** Thank you, Mr Weatherby.

9 Mr Wagner.

10 Questions from MR WAGNER

11 **MR WAGNER:** Good afternoon, Mr Gething, my name is
12 Adam Wagner and I ask questions on behalf of Clinically
13 Vulnerable Families.

14 I want to ask you a few questions all about the
15 pause in shielding, and shielding generally. Picking up
16 on the questions that Mr Weatherby asked you about the
17 decision that you took to pause the pause, if I can put
18 it like that, from the end of July to 16 August.

19 Would you agree that at that time, so in
20 mid-August 2020, there were no vaccines yet, so many of
21 the most vulnerable people remained intensely
22 vulnerable?

23 **A.** Yes. If they got Covid they would have been, yes.

24 **Q.** And would you also agree that it was around this time
25 that children were going to be going back to school

92

1 which would itself increase the risks of the virus
 2 spreading and potentially coming back into vulnerable
 3 people's households?
 4 **A.** I guess children going back to school at the start
 5 of September was one of the risk factors. It's also
 6 worth reflecting, I think Mr Wagner, that in the middle
 7 of August to the end of August, Covid rates were at
 8 their lowest, so the risk at that point in time and
 9 whether it justified continuing with shielding, and if
 10 you're going to give people confidence to do a bit more
 11 then actually having really low prevalence rates is
 12 the time to do that.
 13 **Q.** Yes, and I'm not going to ask you about the decision
 14 itself. But just looking at the risk factors. Do you
 15 also agree that the end of shielding would mean that
 16 shielding people would no longer be eligible for
 17 Statutory Sick Pay when shielding, which would mean they
 18 would potentially be forced to return to the workplace?
 19 **A.** The end of Statutory Sick Pay, yes, that was a factor we
 20 weren't in control of, because that's a UK construct.
 21 But also it would mean that you'd still have to then
 22 consider the individual points about risk assessment for
 23 workers (*inaudible-coughing*) as well.
 24 **Q.** And overall were those all factors that you were taking
 25 into account in that decision to pause the pause?

93

1 means, where they can continue to get advice and
 2 support.
 3 The Welsh Government can't do everything in the
 4 workplace about reasonable adjustments, for example,
 5 because that's an employment construct we're not
 6 responsible for legally, but actually in services we are
 7 responsible for then, yes, that was already taking place
 8 with what we'd asked employers to do and, indeed,
 9 dealing with the private sector it wouldn't have been
 10 done by me, but the economy minister about asking
 11 employers to think about how they deal with the shielded
 12 population.
 13 So we couldn't give a directive but there were
 14 regular conversations with employer groups around what
 15 we would want them to do and we had a couple of
 16 instances where we thought there were problems in
 17 practice. A soft rather than a hard choice, if you
 18 like.
 19 **Q.** Thank you. And just finally, as you decided to pause
 20 shielding and moved away from this approach of guiding
 21 people and providing support for them to stay at home,
 22 did you consider moving away from that approach towards
 23 providing more particular information which could assist
 24 clinically extremely vulnerable and clinically
 25 vulnerable people in assessing and mitigating their own

95

1 **A.** It's a rounded choice. It's not one -- it's not
 2 a single factor but it is the shielded population, some
 3 of them are at work and still working from home, some of
 4 them are not able to work at all because of the nature
 5 of their jobs. Some of them are worried. Some of them
 6 are just keen to get out and about. I'll give you
 7 an example. I -- on a brief family holiday I took, we
 8 met someone who sold us an icecream and she was saying
 9 how well she felt looked after, but she also said that
 10 she was shielded but decided she wanted to go to work.
 11 So it wasn't a requirement, it was an offer of
 12 support and the advice about the risk. People still
 13 have to make their own choices.
 14 **Q.** And just thinking about those risk factors, did you take
 15 or ask anybody in the government to take any particular
 16 steps to address those particular concerns or to
 17 consider what mitigations could be put in place to ease
 18 the process of ending shielding so, for example,
 19 psychological assistance or assistance with reasonable
 20 adjustments in the workplace?
 21 **A.** So it was part of the communication about the advice on
 22 what to do now shielding has been paused, so they had
 23 all had a letter from the CMO, and it was the right
 24 choice, I think, that the letter came from the CMO not
 25 from me, about why shielding has been paused, what this

94

1 risks so, for example, giving them more detailed
 2 evidence about the virus, and the kinds of things they
 3 could do to avoid the virus like masks, ventilation,
 4 those sorts of things?
 5 **A.** That evidence was made available, so not only CMO's
 6 letter directly advising people on steps and measures
 7 but when engaging with health services and advice on how
 8 to minimise your risk for patients in particular.
 9 So there was advice and the challenge at the time,
 10 you know, you couldn't move without hearing about Covid,
 11 and of the clinically extremely vulnerable people that
 12 I met, they took very seriously the risk they had and
 13 the choices they made.
 14 If there is evidence that people didn't know,
 15 I'd be interested in how we learn from it.
 16 **MR WAGNER:** Thank you, those are my questions.
 17 **LADY HALLETT:** Thank you, Mr Wagner.
 18 Ms Waddoup.
 19 **Questions from MS WADDROUP**
 20 **MS WADDROUP:** Good afternoon, Mr Gething, I represent
 21 13 Pregnancy, Baby and Parent Organisations, and
 22 I'd like to ask you, if I may, about some of the
 23 experiences that disabled pregnant women faced.
 24 Ms Carey briefly touched on the "locked out"
 25 report commissioned by the Welsh Government's Disability

96

1 Equality Forum. Paragraph 3.25 of that report concluded
2 that maternity provision was uneven across Welsh health
3 boards during the pandemic with particularly significant
4 impacts on disabled women and the report gives us
5 an example of difficulties that disabled pregnant women
6 had in conveying their genuine needs to be accompanied
7 by an advocate or a partner when visiting restrictions
8 were in place. It also highlighted that the provision
9 of after-birth care by phone was particularly difficult
10 for those who were deaf or had hearing loss.

11 Recommendations were made within that report and
12 included the suggestion that women be allowed to
13 self-register their requirements and that requests for
14 reasonable adjustments are properly formalised to allow
15 for proper consideration of whether a partner or
16 advocate is needed at appointments.

17 My question, Mr Gething, is this. What specific
18 measures, if any, were put in place to monitor health
19 boards to make sure that they were identifying those
20 women and pregnant people who needed additional care and
21 support?

22 **A.** I think there are two points. The first is that the
23 report was published after I was health minister, so the
24 taking forward recommendations would have been for my
25 successor. And, firstly, the detail you're asking

97

1 **PROFESSOR THOMAS:** Good afternoon, Mr Gething. Can you see
2 and hear me?

3 **A.** I can see and hear you now, yes.

4 **Q.** I'm representing FEMHO, the Federation of Ethnic
5 Minority Healthcare Organisations.

6 At paragraph 160 of your statement you note that
7 the risk assessment subgroup concluded that
8 a combination of various factors contributed to the
9 severity of infection including age and ethnicity.

10 Following this conclusion, were any targeted
11 public health interventions introduced specifically to
12 address health inequalities linked to ethnicity during
13 the pandemic?

14 **A.** No. So in my statement I point out that the risk
15 assessment tool was introduced. So this leads from our
16 understanding from the letter from BAPIO, in particular,
17 saying there are problems and there is
18 a disproportionate impact on some ethnic groups. So
19 that's why action is then taken. The risk assessment
20 tool is provided.

21 On the wider public health challenge we started
22 the pandemic not where I'd want us to be on public
23 health, anyway, and since then our challenge is how we
24 invest in public health and improving public health
25 outcomes.

99

1 about, the government monitoring that level of detail,
2 that would be pretty unusual and you'd have to have
3 a system in place to do that with lots of reporting.

4 What we expect is the cultural point about how you
5 listen to women and that the voice of the mother matters
6 about preferences and requirements and the two are
7 different, of course, so -- but to understand what that
8 means in terms of having the best birth experience
9 possible.

10 So, culturally, I would expect that's what we
11 should do and there's been quite a lot of work done with
12 midwives in particular who want to lead on that cultural
13 change happening for every mother including disabled
14 mothers as well, so -- but there isn't a specific
15 monitoring programme in place for disabled mothers. The
16 monitoring oversight does come from the Chief Nursing
17 Officer, leading with the chief nurse and Chief
18 Midwifery Officer as well, and what is happening in
19 health boards and we intervened in health board areas
20 where we've not been satisfied in practice.

21 **MS WADDOUP:** Thank you, Mr Gething.

22 Thank you, my Lady.

23 **LADY HALLETT:** Thank you.

24 Mr Thomas.

25 **Questions from PROFESSOR THOMAS KC**

98

1 So I'm not sure if you're asking about wider
2 public health determinants in the population or if
3 you're asking about staff and the work that we did do
4 with the risk assessment tool where ethnicity was
5 a particular factor, and the fact that we knew that it
6 wasn't even -- not every black and brown person had the
7 same risk, but if you look like me or you, you're at
8 a heightened risk compared to some -- a member of the
9 white population; slightly less risk if you are from
10 different ethnic groups but still often a higher risk
11 than the general population.

12 **Q.** Given the subgroup's findings, do you believe that
13 addressing health inequality, structural racism and
14 variability in healthcare outcomes should form a core
15 part of pandemic strategy planning going forward in the
16 future?

17 **A.** I think it would be sensible to look at those existing
18 healthcare inequalities and the disparity of impact
19 between different ethnic groups. That would be very
20 sensible to do. Even more sensible would be to have
21 this as a standard part of business in the way our
22 healthcare system and wider society works. We know
23 there are different outcomes that are not explained by
24 ethnicity in a positive way -- if you think, for
25 example, of the different experience of black and brown

100

1 mothers in childbirth, that isn't to do with the
 2 pandemic, but those things can be exacerbated in the
 3 pandemic.
 4 **Q.** Okay. Let me move on. Just coming back on to the
 5 subgroup's report. At paragraphs 163 to 164, you
 6 highlight the disproportionate impact of the pandemic on
 7 ethnic minority communities and the importance of
 8 capturing ethnicity-based data included on death
 9 certificates. Question: once ethnicity-based data
 10 becomes available, how was it used to inform
 11 decision-making during the pandemic?
 12 **A.** So the wider ethnicity data and the improvements didn't
 13 really take place in the pandemic. If you look at --
 14 I know you've read the statement. It talks about things
 15 have been done afterwards as a result of the report.
 16 What we did know, for example, was -- I think
 17 I mentioned earlier -- taxi drivers and bus drivers as
 18 occupational groups outside the health service with the
 19 highest rates of mortality, some of those were about
 20 comorbidities, there is an ethnicity factor in that as
 21 well. So what we're then looking at is how do we make
 22 sure there are measures in place to protect different
 23 groups? Taxi drivers, for example, we helped cab
 24 drivers to have perspex screens, provide an extra
 25 barrier for them in place whilst going about their work,

101

1 groups, around ensuring that people could have
 2 confidence they could take the vaccine, and the work
 3 that we did not on a national campaign, some of the
 4 discrete campaigns we ran, were about making sure that
 5 people didn't just have confidence in the service but we
 6 could understand the fears and concerns that people had.
 7 None of that is perfect. I think there are times
 8 where other commentators make the mistake of thinking
 9 that ethnic minorities are a single community as opposed
 10 to a range of different factors you need to take account
 11 of. That doesn't mean that we're hard to reach, because
 12 we're pretty obvious, it means you've got to make an
 13 effort to talk to us in the way you talk with the wider
 14 population, and so we definitely did do that and perhaps
 15 that example around messaging around vaccination is the
 16 best example of a specific communication to try to be
 17 culturally sensitive, but I'm always ready to listen and
 18 to learn --
 19 **Q.** Let me come to my last question and it's this. Based on
 20 your experience, how could this approach be strengthened
 21 to improve engagement and outcomes for minority ethnic
 22 communities in future public health emergencies? What
 23 can we do better?
 24 **A.** I think we have got to fix what we do every day, because
 25 in the pandemic it's under more stress and strain. You

103

1 and the risk assessment tool is an example of what we
 2 did in the health service, but it was then adopted in
 3 wider public services in particular, including
 4 non-devolved services, the police services in Wales were
 5 interested in the risk assessment tool and how they
 6 could adapt and use it as well, to try to make sure that
 7 people could still be in work but redeployed to areas
 8 that took account of their risk.
 9 **Q.** I think you may have touched upon my next question so
 10 I'll skip over that and come to my final area, if I may,
 11 and this is on engaging with minority ethnic
 12 communities.
 13 Did the Welsh Government actively engage with the
 14 black, Asian, minority ethnic healthcare workers, health
 15 organisations and community leaders to ensure that
 16 information about Covid-19 prevention and treatment and
 17 healthcare guidance was communicated in a culturally
 18 sensitive and accessible way?
 19 **A.** We did at various points in time. So not just the work
 20 of the subgroups that Professor Ogbonna and
 21 Professor Keshav Singhal chaired to deliver the risk
 22 assessment tool, but that engagement took place -- and
 23 I'll give you examples. When we were looking at
 24 vaccination, understanding the different cultural
 25 sensitivities around vaccination, around different faith

102

1 are making extraordinary choices at a pace that no one
 2 is comfortable with. But, actually, if you still have
 3 a problem with engagement in the first place, if people
 4 think, I'm not sure if I trust the health service in the
 5 same way someone else does; if you think, if I go into
 6 labour will my choices be respected in the same way as
 7 another mother next to me, that affects not just how you
 8 feel about the service but affects outcomes as well.
 9 And one of the things we definitely need to do is
 10 we do need to take a more serious approach to public
 11 health inequalities because they map on to socioeconomic
 12 inequalities and they map additionally on to race
 13 inequalities as well. So get that right, then I think,
 14 actually, you're better geared up to properly deal with
 15 a pandemic and recognise -- and lots of infectious
 16 diseases have a different effect for different people.
 17 Not just age and comorbidities, but race is definitely
 18 going to be -- I would be surprised in a future pandemic
 19 if race isn't a factor but the least you need to do is
 20 to consider it at the outset.
 21 **PROFESSOR THOMAS:** Thank you, Mr Gething.
 22 Thank you, my Lady.
 23 **LADY HALLETT:** Thank you, Mr Thomas.
 24 Ms Sivakumaran.
 25 Oh, it's you, Miss Hannett, is it?

104

1 **MS HANNETT:** Sorry, my Lady, there is a degree of confusion
2 between my junior and me, but I am asking the questions
3 this morning.

4 **LADY HALLETT:** Thank you.

5 **Questions from MS HANNETT KC**

6 **MS HANNETT:** Mr Gething, I appear on behalf of the
7 Long Covid groups and we are very grateful to Counsel to
8 the Inquiry who has asked a number of the questions for
9 which we had permission so hopefully I take this
10 relatively shortly.

11 In particular I wanted to ask you questions, if
12 I may, on Long Covid services. You referred this
13 morning to the rehabilitation framework and in
14 particular in January 2021 you were provided with
15 ministerial advice on Long Covid which stated that
16 health boards will need to avoid over medicalising
17 people and avoid referrals to unnecessary investigations
18 and increasing unnecessary demand on secondary care.

19 Were you aware that the advice in that ministerial
20 advice prioritising rehabilitation and discouraging
21 referrals for clinical investigation conflicted with the
22 NICE guidelines which recommended clinical management of
23 symptoms of Long Covid?

24 **A.** I'm not sure that's a fair characterisation. One of the
25 things we tried to do, and particularly on the journey

105

1 particular side has a veto, and it's still about: is
2 a specialist clinic model the appropriate model to
3 deliver the best care across Wales? I wasn't persuaded
4 that it was; neither were my advisers, and I know you've
5 had evidence on this from Judith Paget. But it's still
6 about learning at what point is specialist intervention
7 appropriate and where should that be? Does it need to
8 be in a named Long Covid clinic centre or is it actually
9 about how our service as a whole understands the needs
10 of the population including people living with
11 Long Covid.

12 **Q.** In that respect, in this Inquiry, Professors Brightling
13 and Evans, who are the Inquiry's Long Covid experts,
14 have given evidence that they recommend one-stop clinic
15 in Wales, in other words specialist Long Covid clinics,
16 because the complex and novel multi-system nature of
17 Long Covid requires access to a cluster of skills and
18 knowledge in specialist clinics. So, on reflection, in
19 the light of that evidence, do you agree that it would
20 have been appropriate to introduce one-stop clinics in
21 Wales?

22 **A.** I think it's appropriate to look at the evidence and
23 then for that evidence to be put before a minister to
24 make a decision. I'm not going to try to insert myself
25 as a clinical decision-maker. I used to be a lawyer,

107

1 to having a more prudent healthcare system, is not to
2 overmedicalise conditions where they don't need to be.
3 That doesn't mean that appropriate clinical and medical
4 intervention should not be undertaken.

5 So I've never considered the advice to say: where
6 medical treatment is appropriate don't do it, try to
7 manage those people away. But it is about how you try
8 to manage the reality of people's symptoms and how
9 rehabilitation, often therapy services, can help to do
10 that effectively. So, with respect, I don't accept the
11 characterisation that you're placing on the advice
12 I received.

13 **Q.** You referred also this morning to discussions with
14 patient representative groups and at meetings with the
15 Welsh Government in February and March 2021, so a little
16 after the ministerial advice we've just discussed,
17 Long Covid Wales raised concerns about the management of
18 Long Covid and asked for Long Covid clinics to be
19 provided. Why wasn't the decision not to open
20 Long Covid specific clinics revisited when those
21 concerns were raised?

22 **A.** In listening to people you have to understand what
23 they're asking for and why, and what you can deliver in
24 the service to deliver the best sort of outcomes.

25 Trying to co-produce a model doesn't mean that one

106

1 not a doctor, and I'm certainly not a clinical expert
2 now, but it's one of the things you have to do as
3 a minister, is, where there is more than one clinical
4 point of view you have to consider advice and make
5 a choice, and that is a choice for the current health
6 secretary here in Wales.

7 **MS HANNETT:** Thank you, my Lady.

8 Thank you, Mr Gething.

9 **LADY HALLETT:** Thank you very much, Ms Hannett.

10 I think it's Ms Shepherd next.

11 **Questions from MS SHEPHERD**

12 **MS SHEPHERD:** Good afternoon, Mr Gething. I appear on
13 behalf of Covid-19 Bereaved Families for Justice Cymru.

14 I am going to start off with the critical care
15 questions and the evidence you gave earlier the system
16 which was that the system did not become overwhelmed.
17 You also said that an indication of an overwhelmed
18 system is people not getting the care when they
19 needed it.

20 The families that I represent have given examples
21 of their loved ones not being escalated to the level of
22 care they believe would have saved their lives, in
23 particular Paul Jones gave evidence in this module that
24 his daughter Lauren was not escalated from CPAP to
25 ventilation and then to ECMO because there was

108

1 insufficient capacity in the system for her to have
2 access to that treatment. That's just one example.

3 Do you agree that your statement that the system
4 was not overwhelmed is from looking at the data you
5 received but it may not be reflected by the situation on
6 the ground?

7 **A.** Well, I think we had the anecdotal evidence that was
8 brought before me today where clinicians said they were
9 making a choice where any might have made a different
10 one in normal times, and I think it's important to
11 reflect on that and what that means. But I never had
12 an instance brought to me where inappropriate choices
13 had been made and that affected outcomes. Being
14 sensitive and understanding how people have suffered
15 loss and bereavement and the question of if something
16 else had happened would my loved one still be here, is
17 important to reflect in way that's sensitive and
18 understands how our whole system works.

19 So I don't think that changes any of my evidence
20 or the importance of learning from what really did
21 happen.

22 **Q.** Professor Fong gave evidence to the Inquiry that the
23 data does not tell the whole story and that it does not
24 always reflect what was happening on the ground. You
25 mentioned the example that was given earlier from the

109

1 beds?

2 **A.** No, that would have been a separate report. And again,
3 when we're thinking about staffing, we're thinking
4 about: what responsibility do I have? What
5 responsibility does our system have? And how are we
6 making choices about how the whole system operates?

7 So the compromises you make on turning off other
8 parts of the system so you can redeploy staff, to make
9 sure the beds are staffed properly in this environment,
10 it was never the physical bed that was the biggest
11 limiting factor, it was always the staff to deliver the
12 care.

13 And it's also about understanding the additional
14 pressure you're under, which is why we changed -- well,
15 I changed the reporting on how you reflect current
16 potential capacity against normal capacity, show the
17 flex that has been used, and that reflects other parts
18 of the system that are not operating as well.

19 **Q.** Do you agree that just because the global figure across
20 Wales for critical care beds was not breached does not
21 mean that all patients received the treatment that they
22 needed at the relevant time?

23 **A.** No. I think you're conflating two quite different
24 things. The global figure not being breached showed
25 that we had more capacity to surge into. Whether people

111

1 critical care doctor. If no equivalent study to that of
2 Professor Fong was conducted in Wales, how were you as
3 health minister able to understand whether the data you
4 were receiving gave you an accurate picture of the
5 pressures on the ground?

6 **A.** Well, the picture of pressures on the ground is partly
7 driven by the data but it's also the direct
8 conversations and reporting that take place as well.
9 That's with the chief executive of NHS Wales, the Chief
10 Medical Officer, the Deputy Chief Medical Officer, with
11 the chief nurse, with the Chief Scientific Adviser for
12 Health, the therapies adviser, the chairs and chief
13 execs, the direct engagement with unions and medical
14 colleges. So there's quite a lot of information that
15 isn't just about data but it is about experience and
16 what people are doing on the ground. And as a minister
17 you have to try to understand those things and still
18 make choices. The data is always going to matter but
19 I wouldn't disagree with the view that it's not the only
20 thing that matters.

21 **Q.** Dealing with the data then, at page 78 of your witness
22 statement you provide screenshots from the daily NHS
23 update showing the critical care capacity in Wales. Did
24 that data show you whether there was the staffing,
25 medicine and other necessary equipment to go with those

110

1 got the appropriate treatment is actually a matter about
2 what was taking place with and for that person. And
3 even in a time where capacity is not breached it's
4 possible for people not to get the care that they need.
5 In the pandemic, and understanding what we were doing
6 and why, it was never brought to my attention, with
7 an individual example or a complaint from not just
8 leaders but the different groups that I met with, that
9 people were not getting critical care they needed that
10 would have made a difference. That doesn't mean it
11 didn't happen but it certainly was never brought to my
12 attention as far as I recall, counsel.

13 **Q.** Thank you. I'm going to move on to testing now.

14 To your paragraph 304, you confirm that you
15 announced the policy of routine testing of asymptomatic
16 healthcare workers on 4 December 2020. The UK made that
17 announcement over two weeks earlier, on
18 16 November 2020. Why was there a delay in Wales?

19 **A.** Sorry, you said about 16 November?

20 **Q.** So it was 16 November when it was announced in the UK,
21 and England. And it was 4 December in Wales.

22 **A.** I think you've had an answer on this from previous
23 evidence about LAMP technology being used in England
24 that we didn't have in Wales. So we were able to do
25 this when lateral flow devices were in large number.

112

1 And I think if you look at paragraph 303, I point
2 out the Chief Scientific Adviser had been providing
3 updates on the mass testing programme and the
4 availability of lateral flow devices.
5 So if we'd understood that lateral flow devices
6 were not going to be available any time in the near
7 future, we might have had to make a choice to invest in
8 the LAMP -- which I think is a laboratory form of tech,
9 and the staff to do that -- that would have meant
10 investing in infrastructure and in staff to do that.
11 That wasn't a practical thing to do within two weeks.
12 When we did then though get access to reliable lateral
13 flow tests, that's when the choice was made, because we
14 could deliver it.

15 **Q.** And although that roll-out was due to be rolled out in
16 full from January 2021, evidence has been provided to
17 this Inquiry, particularly from Professor Kloer, that it
18 was not in fact rolled out until mid-March and as late
19 as July 2021 in some cases.

20 Do you accept that that that that was
21 an unacceptable delay?

22 **A.** Yes, that -- I was surprised by that evidence, because
23 I would have expected for something like that that I'd
24 have been made aware and that Welsh Government officials
25 would have been aware as well about the fact that there

113

1 particular at page 45 of this document we have
2 recommendations 7 and 8.

3 Recommendation 7:

4 "The Welsh Government, working with NHS Wales,
5 must develop a clear plan for regular and repeated
6 testing of health and social care staff, including
7 asymptomatic staff."

8 And I won't read out the recommendation in full
9 but it sets out some steps to be taken to ensure that
10 there is sufficient testing capacity. Given that the
11 regular testing regime was not in fact rolled out until
12 spring/summer of 2021 in some cases, do you agree that
13 there was a failure to carry out these recommendations?

14 **A.** Well, making a recommendation is one thing. You've
15 actually got to be able to do it.

16 And, you know, the scrutiny is about a challenge
17 for the government. That doesn't mean that you can
18 automatically deliver testing capacity. And I think in
19 evidence you've heard about how Lighthouse labs in
20 particular went through phases where they were reliable,
21 increased capacity, but actually there were also times
22 where there were real problems that affected the
23 care home sector in particular. So delivering testing,
24 and repeat testing, for health and social care staff is
25 a practical challenge that simply making the

115

1 was a different choice being made.

2 As far as I recall, nobody came to me and said,
3 "This isn't happening and nothing is being done about
4 it". So I was surprised at that part of the evidence
5 from Dr Kloer.

6 **Q.** A follow-up question on that. Did you do anything to
7 investigate into whether the testing regime was being
8 rolled out in a timely manner by the health boards?

9 **A.** Well, I saw all the figures that were coming in about
10 the large numbers of tests that were being done and the
11 availability of workforce, so I could see that more and
12 more healthcare workers were getting tested and what
13 that meant in terms of the availability of staff. And
14 that's particularly important as you move into what was
15 a high prevalence time and a rising tide of Covid
16 infections through December and into January.

17 So understanding that staff are able to work and
18 have negative results is really important.

19 **Q.** If I could have up on the screen, please, INQ000349686.

20 Just to locate you in this document, it's the
21 report arising from the Senedd's social care and sports
22 committee's inquiry into the impact of the Covid-19
23 outbreak and its management on health and social care in
24 Wales, and it's dated July 2020.

25 A number of recommendations are made, and in

114

1 recommendation doesn't actually help you to deliver.

2 And we didn't actually have the tools to be able
3 to deliver this in the way that's envisaged until
4 lateral flow devices were available. I wish they were
5 available earlier but the simple fact is that they
6 weren't.

7 **Q.** I'm going to return then to my last topic of
8 questioning, which is the NHS estate and infrastructure.
9 The chief information officer at Cwm Taf Morgannwg is
10 critical of the inability to extract data from NHS
11 systems in Wales and states that by 24 March 2020 daily
12 laboratory reports were available for NHS sites that
13 could be linked to other hospital datasets but no
14 consideration was given to differentiating community
15 from hospital-acquired infection.

16 Do you agree that the data collection and
17 processing systems in Wales were insufficient to meet
18 the demands of the pandemic?

19 **A.** Well, everyone in our system had to shift. And so, for
20 the pandemic that we faced, what we had, it wasn't
21 sufficient when we started.

22 And, look, I think the information officer is
23 a high quality public servant who is making a point
24 around what we need to do to improve, but that's the
25 point of it, isn't it? About how you understand what

116

1 you can't do but will help you to deliver something
 2 better. So not being able to link those different parts
 3 was important for us to understand healthcare-acquired
 4 infection and community infection. Not the only thing
 5 but it would certainly have helped us.

6 **Q.** You spoke earlier about the challenges that the ageing
 7 NHS estate in Wales posed for ventilation. When the
 8 pandemic struck in January of 2020 you had had a health
 9 portfolio since September 2014. What steps had you
 10 taken prior to the pandemic to improve the ageing
 11 NHS Wales estate?

12 **A.** Well, we'd undertaken a number of investments. So the
 13 way that healthcare capital works, and I think
 14 Dr Goodall has given you some evidence on this as well,
 15 is both the amount but then how it's then allocated,
 16 what the government supports and allocates, with
 17 business cases that are made to us by health boards, and
 18 discretionary capital that health boards themselves use.
 19 Now that is really often about maintenance. And,
 20 you know, there's a significant maintenance challenge in
 21 the estate because of the amount and the age of the
 22 wider estate. There are some invest to -- invest to
 23 save opportunities as well, and those normally require
 24 approval at a ministerial level to -- but those are more
 25 often to about delivering the more efficient service

117

1 example being introducing perspex screens. And that's
 2 because, if you think about -- and I go back to earlier
 3 evidence on this -- Glangwili hospital is the oldest
 4 district general hospital in NHS Wales. So you compare
 5 that to the Grange hospital, where you have individual
 6 rooms where infection prevention and control should be
 7 a much easier thing to do in terms of the shape of the
 8 estate.

9 Now, you can't simply build a new hospital without
 10 having the money to do it, and you can't simply say
 11 we're closing Glangwili during the pandemic. So to do
 12 that you've got to compromise, and so the perspex
 13 screens that were installed were a compromise to try to
 14 improve IPC practice, to have separation between
 15 patients. You've also got things like the way that
 16 washing facilities are delivered and shared.

17 So as our estate has been modernised and
 18 retrofitted, you'll see improved IPC practice, for
 19 example, in the new Prince Charles Hospital -- well,
 20 I say "new", it's been significantly refurbished. Still
 21 on the same footprint but the changes in the layout
 22 should improve patient experience and IPC, as well as
 23 new services that were not envisaged when that hospital
 24 was originally built.

25 **Q.** This morning you discussed how there isn't a control and

119

1 rather than spending more money, to keep the service
 2 running and to deliver improvements in it.

3 So once I had made the choice early in the term to
 4 approve the Grange University Hospital, an awful lot of
 5 our available health capital had been spent, so the size
 6 of the capital we have available to us helps to govern
 7 the sort of choices we can make.

8 I think in Glangwili, for example, I had overseen
 9 and had agreed capital expenditure on improving neonatal
 10 provision there. That was particularly useful when it
 11 came to parts of the pandemic but that wasn't the reason
 12 why I approved it.

13 So in each of those areas you have to make the
 14 best choice available with the resource you have, and as
 15 you know, our capital budgets have been reduced in real
 16 terms and in cash terms at various points in time
 17 overall during my time in the government. And that's
 18 the unavoidable truth of the matter. I wish we had more
 19 money but we did what we did with the funds we had.

20 **Q.** Those are the long-term measures. What urgent measures
 21 did you take to minimise the impact of the ageing NHS
 22 estate on the ability to implement IPC measures during
 23 the pandemic?

24 **A.** So I think, again, you've heard evidence on this from
 25 others, including Dr Atherton and Jean Wright, an

118

1 command arrangement in Wales. Do you think that the
 2 Welsh healthcare system set-up, namely where the health
 3 boards and trusts have sovereignty and operational
 4 control, led to difficulties in ensuring implementation
 5 of IPC measures across all health boards and trusts in
 6 a uniform manner?

7 **A.** I think the challenge is if you simply say "We'll have
 8 a central command and control where someone in Cardiff
 9 will tell everyone what to do and they must do it" --
 10 you can do that with directions. It doesn't mean you
 11 get compliance. It doesn't mean you get good practice.
 12 It doesn't mean you get the culture you need in
 13 organisations.

14 I think our model is broadly the right one but it
 15 is how you make sure that model works. How, when people
 16 are making different choices, that they're clear about
 17 the fact they're making different choices through their
 18 own executive infrastructure and at board level. And on
 19 issues like this in the pandemic, how that is properly
 20 communicated to Welsh Government so it doesn't end of
 21 being a surprise. It doesn't mean that that will be the
 22 wrong choice though.

23 When you come back to some of the questions I was
 24 asked earlier -- the situation in Worthybush, in
 25 Pembrokeshire, was markedly different to the situation

120

1 in Wrexham Maelor at various points in the pandemic --
2 trying to tell people what they must do, regardless of
3 local circumstances, is not something that can always
4 work.

5 And IPC measures, though, I think the rigour that
6 is attached to those is something where you still are
7 going to need local leadership and local -- not just
8 expertise but local cultural agreement that that's the
9 right thing to do for staff and patients. Even if
10 I made all those choices in my office in Cardiff.

11 **MS SHEPHERD:** Diolch yn fawr. Those are my questions.
12 Thank you, my Lady.

13 **LADY HALLETT:** Thank you very much, Ms Shepherd.
14 Thank you very much indeed, Mr Gething. It's
15 obvious you spent some time preparing to give evidence
16 and I'm really grateful to you for taking that trouble
17 and for helping us today.

18 I can't guarantee we won't ask you to come back
19 but I promise you we'll limit the burden we place on you
20 as much as we can. Thank you for your help.

21 **THE WITNESS:** Diolch yn fawr iawn, my Lady. Thank you.

22 **(The witness withdrew)**

23 **LADY HALLETT:** Very well, I shall return at 1.55.

24 **(12.58 pm)**

25 **(The short adjournment)**

121

1 **Q.** If we can begin today considering the period when you
2 first came into the role of Minister for Health and
3 Social Services in May 2021, so at this point the second
4 wave of Covid had ended and Covid-19 rates in the
5 community were relatively low at that point.

6 In relation to health rather than social services,
7 that aspect of your portfolio, what were your priorities
8 when you became Minister for Health and Social Services
9 and how did you identify those priorities?

10 **A.** Well, I was still very aware that we needed to continue
11 with the vaccination programme, so that was important.
12 I was very aware that we needed to switch the planned
13 care programme back on, to get back up to speed. There
14 were issues in relation to social care. I was very
15 concerned about Long Covid and the need to make sure we
16 had a good programme in relation to that. I was
17 concerned about making sure that Test, Trace, Protect
18 was still in place when we needed it.

19 So those are some of the key things that I was
20 focused on.

21 **Q.** And did you identify those priorities because of what
22 you knew already from working in government or was it
23 your officials within the Welsh Government, Civil
24 Service effectively, who identified those priorities to
25 you?

123

1 **(1.55 pm)**

2 **LADY HALLETT:** Ms Nield.

3 **MS NIELD:** My Lady, please may I call Baroness Eluned
4 Morgan.

5 **BARONESS ELUNED MORGAN (sworn)**

6 **LADY HALLETT:** Baroness Morgan, I know how busy you must be,
7 and I promise you we will finish your evidence today so
8 you can get back to your other duties.

9 **THE WITNESS:** Thank you.

10 **Questions from COUNSEL TO THE INQUIRY**

11 **MS NIELD:** Can you give your full name, please.

12 **A.** Eluned Morgan.

13 **Q.** Baroness Morgan, prior to becoming the First Minister of
14 Wales, you were the Minister for Health and Social
15 Services from May 2021 to March 2024; is that correct?

16 **A.** That's correct.

17 **Q.** I think prior to that role you served as the Minister
18 for Mental Health, Wellbeing and Welsh Language
19 from October 2020 to May of 2021; is that right?

20 **A.** That's correct.

21 **Q.** And I think when the pandemic began you were the
22 Minister for International Relations and the Welsh
23 Language, a role that you held from December 2018
24 to October 2020; is that right?

25 **A.** That's correct.

122

1 **A.** So I had a meeting when I first started with the
2 director general of health, who ran through a whole
3 series of challenges that were facing the NHS, and they
4 were numerous, so it was a question then of where do you
5 focus your priorities, where do you focus the attention.
6 I mean, this is a huge brief and it's very difficult to
7 get your head around such of lot of things. So it made
8 sense to try to focus.

9 **Q.** If we can look at your powers and responsibilities as
10 Minister for Health and Social Services, and you set out
11 in your witness statement the various areas for which
12 you had responsibility, but you explain that, in terms
13 of the healthcare system in Wales, operational
14 decision-making was the responsibility of the local
15 health boards and the NHS trusts, who had a broad
16 discretion to formulate their own policies, and that
17 your role as minister was limited to focusing on the
18 strategic direction of the healthcare system, approving
19 the health board plans and providing funding. And this
20 Inquiry has heard from the director general at the time,
21 Andrew Goodall, who explained that, as minister, you
22 retained responsibility in a health emergency for
23 preparedness, capacity and increasing capacity and
24 resilience.

25 We also heard that there isn't a central health

124

1 emergency organisation that can take national command
2 and control of the healthcare system in Wales. And so
3 can you help us with this, do you think, with your
4 experience having been the minister during the latter
5 part of the pandemic, would there be benefit, in
6 a pandemic situation, either for the Welsh Government to
7 have some greater powers to direct the response of the
8 healthcare system or for some other national body to be
9 able to take command and control of the NHS to
10 co-ordinate the pandemic response?

11 **A.** I think some of that was done centrally, so the
12 vaccination roll-out, for example, was very much
13 centrally driven but now, by now, there is an NHS
14 Executive that exists that didn't exist at the time, so
15 that centralised approach is something that's been
16 developed since then.

17 **Q.** I think it's right that the NHS Executive doesn't have
18 statutory powers so it doesn't have the powers to direct
19 the healthcare system, is that right, or is it the
20 minister can use the NHS Executive effectively to give
21 ministerial directions?

22 **A.** So we can -- there are methods of ensuring that the NHS
23 health boards do what we want them to do, including
24 through the framework and including, obviously, through
25 financial means. So we have accountability mechanisms

125

1 Sometimes if you're not in a pandemic you can get
2 to the front line and you can speak to people on the
3 front line and get a sense of what's happening from the
4 front line. It's more difficult in a pandemic because
5 there were rules about who should be going into
6 hospitals. So that kind of triangulation that you can
7 do usually.

8 But obviously we did have advice and I spoke
9 regularly to different organisations. BMA and lots and
10 lots of organisations were coming in regularly, just
11 obviously on online.

12 **Q.** Can we have a look at some of the information and data
13 that was made available to you in terms of hospital
14 capacity first of all. And I think it's right that you
15 received regular emails about hospital capacity, which
16 included a table of the available and occupied beds.

17 And if we can have a look at one of the example
18 emails that you've provided to the Inquiry.
19 [INQ000479978] Thank you.

20 This is from 16 June 2021, and we can see there
21 this is an "update from Andrew". I think that will be
22 Andrew Goodall, I assume, the "Minister NHS update for
23 16 [June]":

24 "The NHS has had a busier week and started with
25 some visible pressures on Monday, with at one point

127

1 as well so have regular meetings with the health board
2 chairs. And certainly later on I was holding them to
3 account in a very detailed way in terms of what was
4 being delivered.

5 So accountability is certainly something that
6 I noticed needed to be tightened up and since then
7 there's been an accountability review.

8 **Q.** Thank you. You also explained in your witness statement
9 that in the discharge of your ministerial
10 responsibilities for the healthcare system you relied
11 heavily on the advice from the Chief Medical Officer,
12 the Chief Nursing Officer and also the Director General
13 of the Health and Social Services Group.

14 Did you always feel that you had the information
15 that you needed or did you ever feel that you needed
16 more specific expertise or detailed information on
17 a particular topic?

18 **A.** I think in retrospect I'd have liked to have other
19 views, and that's one of the things that I developed
20 since, was to get to set up a system where we have
21 a ministerial advisory group made up of people who are
22 outside the system, including people from -- who are
23 outside, from England, who are kind of kicking the tyres
24 on how we do things. I think that's something
25 perhaps -- it was very difficult.

126

1 7 Level 3 sites. Yesterday felt particularly
2 difficult and consistently across Wales -- with high
3 'normal' levels of activity and evidence of long
4 handover delays and constraints on patient flow ..."

5 And says:

6 "This morning still reported 7 level 4
7 sites ..."

8 The Inquiry has heard about different levels in
9 different mechanisms, CRITCON, and so on and so forth.
10 Do you know what level 4 sites meant in this context?

11 **A.** Yeah. I think it's probably worth noting I'd only been
12 in the job a month when this was sent, so I was really
13 trying to learn how the system worked and I wasn't too
14 familiar with how the levels were set, which is why
15 I asked the question, and I didn't quite understand how
16 they could say that some of them were at perhaps a lower
17 level than I expected sometimes, because I knew there
18 was a lot of planned care pressure. But this was about
19 urgent pressure, it was about day-to-day pressure and
20 that's what this particular approach -- the escalation
21 process is about the day-to-day and the pressure on the
22 system on the day, rather than the kind of more planned
23 care concerns that I was starting to be worried about.

24 **Q.** So can you help us, what does level 4 mean in that
25 context?

128

1 **A.** So level 4 means that they are already using the
 2 additional bed capacity that needed to be used but
 3 level 5 would be the one where actually everybody is in,
 4 everybody has their leave cancelled, everybody -- so
 5 this was one down from that. But, you know, level 4 was
 6 pretty consistent in many places for a long time, and
 7 indeed even today the pressures are huge and we have
 8 pretty consistent level 4 levels still.

9 **Q.** If we can go over the page on that email, please, we can
 10 see the table and we've seen a similar table from
 11 earlier both in March and in April of 2020, prepared by
 12 Andrew Goodall when he gave his evidence, but we can see
 13 that the numerical data that you're provided with at
 14 this point, and this is really between waves 2 and 3, in
 15 June of 2021, and so we can see that you're shown there
 16 the number of available beds in critical care and the
 17 occupied beds in critical care and how many of those
 18 occupied beds are occupied by Covid-19 patients. We can
 19 see there is only one Covid-19 patient in critical care
 20 at that time.

21 And we can also see under "Total Beds", on the
 22 right-hand side, number of non-Covid-19 occupied beds,
 23 there are just over 8,000 occupied non-Covid-19 beds.
 24 This is outside of critical care, non-critical care it
 25 would appear.

129

1 about that differentiation. It's intensive care or high
 2 dependency care and the staffing ratios that
 3 differentiate between those two levels of care, and
 4 indeed there isn't any information on this about what
 5 staffing ratios are having to be employed, which is
 6 another measure of surge capacity and how stretched the
 7 critical care units might have been.

8 Albeit that this is at a time between the Covid
 9 surges, by the time that the Omicron surge hit in Wales,
 10 would it have been useful to know about staffing ratios
 11 in critical care, or indeed the number of patients
 12 receiving CPAP, for example, outside of critical care?
 13 That's something that we saw that had been -- that data
 14 had been collected earlier in the pandemic. It doesn't
 15 seem to be here. Were you ever given any information
 16 about patients receiving -- Covid patients receiving
 17 CPAP and how close that was to capacity?

18 **A.** I can't remember getting that information on CPAP but if
 19 you look at the number of Covid-19 patients in occupied
 20 beds, you know, they were actually quite low.

21 **Q.** At this point, yes, but later in the pandemic when the
 22 Omicron wave hit --

23 **A.** Sure.

24 **Q.** -- and there were more patients hospitalised, were the
 25 data categories -- did they change at that point, when

131

1 In terms of what isn't shown on that, it doesn't
 2 appear from this that you're told what proportion of the
 3 non-critical care beds are occupied. We can see that
 4 critical care beds occupied 72% but you're not told how
 5 much available capacity there is for non-critical care.
 6 Would that have been useful for you to know apart from
 7 just knowing that you're at level -- that the sites were
 8 at level 4? Would it have been useful to know quite how
 9 full the general acute capacity was in Welsh hospitals?

10 **A.** I remember on a -- certainly on a weekly basis
 11 monitoring this quite closely and just trying to work
 12 out how near to capacity we were. So although it might
 13 not have been on this particular graph, I remember the
 14 note being clear about how many critical care beds we
 15 had, and therefore you can work out pretty quickly how
 16 many were available to us.

17 **Q.** And what about the non-critical care beds, the other
 18 activity, of the -- just the general acute beds that
 19 would be on a normal acute ward? Would it have been
 20 helpful to know how many of those were unoccupied?
 21 I think you're only given on here, it appears, just the
 22 number of beds that were occupied.

23 **A.** I was very aware that we were very much near capacity.

24 **Q.** This table also doesn't give any idea of whether those
 25 critical care beds are level 2 or level 3. We've heard

130

1 there were more Covid patients? Were you given more
 2 detail about the kind of clinical support that was
 3 available for Covid patients?

4 **A.** I can't remember getting that information at that time,
 5 no. But I was aware that there was a lot of pressure in
 6 terms of staffing in critical care, and I was aware,
 7 particularly later, that there were difficulties in
 8 recruiting to emergency departments in particular and
 9 critical care as well.

10 **Q.** I think also on here we can't see whether there are any
 11 beds available in field hospitals. Were you given
 12 information about any available beds in field hospitals,
 13 was that something that you were given regular updates
 14 on?

15 **A.** No, because I think the kind of -- I think they were
 16 included in the health boards' numbers so, you know,
 17 there was a surge capacity, effectively, which was
 18 counted in these numbers.

19 **Q.** Thank you. Aside from this sort of numerical data then,
 20 you mentioned before about how difficult it was to go
 21 into hospitals and find out what was happening on the
 22 ground. How did you hear from frontline healthcare
 23 workers about the pressures on the ground aside from the
 24 numbers?

25 **A.** So as soon as I was able to enter hospitals I used to do

132

1 a lot of unannounced visits, I used to just turn up at
2 hospitals, and get a sense from patients waiting how
3 long they had been waiting. I'd manage, in particular,
4 to go into emergency departments and to listen to what
5 people on the front line were saying, and they were
6 always really pleased because quite often if you turn up
7 as a minister they've cleared everything up before you
8 arrive. But what I got was a much more authentic view
9 on pressures and what was going on and I think it was
10 really appreciated because it meant that I could speak
11 to them. You know, if you go in and you're surrounded
12 by 15 managers you don't get to the people who are
13 actually coping with it day in, day out.

14 And I found that really useful. I did it around
15 Wales quite a lot as soon as I was able to get into
16 hospitals when the levels of the infections had reduced.

17 **Q.** And did the picture that you -- that emerged from
18 speaking to those people when you went to visit
19 hospitals, was that a picture that was in contrast to
20 the information you were getting from the purely
21 numerical data, or did those two things marry up?

22 **A.** They definitely married up but what you don't get from
23 numbers is a sense of how people are feeling on the
24 front line, of the pressure they're under, of the
25 intense -- intensity of the work that they're

133

1 prevention and control measures in Welsh hospitals.

2 In your witness statement the first briefing on
3 nosocomial infection rates that you identify is from
4 30 June 2021. Do you know whether that was the first
5 time that particular issue had been brought to your
6 attention as health minister?

7 **A.** Yes, I'd been in post about a month and a half by that
8 point.

9 **Q.** And if we can have a look, please, at the briefing that
10 you were provided with at that time.

11 We can see that Public Health Wales data for
12 1 March 2020 to 30 May 2021 indicates 7,127 probable and
13 definite nosocomial Covid-19 infections in Welsh
14 hospitals.

15 And on page 2 we can see that:

16 "Health board self-reported data to the Welsh
17 Government outbreak reporting system indicated that from
18 23 November to 23 June 2021, during the 'second wave',
19 there were 232 outbreaks in Welsh hospitals in which
20 3387 patients and 1360 members of staff tested positive
21 for COVID-19."

22 And then we see below that that there's a note
23 that:

24 "All nosocomial Covid-19 infections are 'incidents
25 of patient safety' and therefore health bodies are

135

1 undertaking. I even went out and spent the day as
2 an ambulance worker with the ambulance drivers and,
3 you know, there were people who were breaking down and
4 it really brings it home to you when you realise the
5 pressure they're under. No graph is going to tell you
6 that.

7 **Q.** The Inquiry has heard repeatedly that there was a focus
8 in all four nations of the UK on ensuring that the NHS
9 was not overwhelmed. What did you understand
10 "overwhelmed" to mean? What would your measure of the
11 NHS being overwhelmed be?

12 **A.** I guess there's different ways of describing what
13 "overwhelmed" means. Did we have enough beds? I don't
14 we never ran out of beds but were the people working in
15 the NHS overwhelmed? Yeah, I think there were a lot of
16 people who were working in the NHS who were definitely
17 overwhelmed and I'll never forget speaking to some of
18 the people on the front line about how they were
19 feeling, they were breaking down, and there was a group
20 who came to present at the Senedd, the Royal College of
21 Emergency Medicine, they came to the Senedd and it was
22 really harrowing to hear what they had been going
23 through and how clearly traumatised they were.

24 **Q.** Can we move on to a new topic, please, and that's
25 nosocomial infections and IPC measures, infection

134

1 obliged to investigate these under Putting Things
2 Right."

3 I think that was a pre-existing process that
4 existed for patient safety investigations in Wales.

5 And then below that we can see that there's
6 reference to the national framework on managing patient
7 safety incidents following nosocomial transmission that
8 requires health body to contact patients or their
9 families where harm has been caused.

10 And then there's a note that potential claim
11 values vary widely. Initial estimates range from
12 £7.7 million to £69 million.

13 Do you think that this focus on the cost of
14 potential civil claims arising from individual cases
15 rather than adopting a no-blame culture may have
16 deterred local health boards from candour and openness
17 when they were trying to tackle this ongoing problem of
18 nosocomial transmission in Welsh hospitals?

19 **A.** Well, I certainly wasn't aware of a focus on money.
20 I think the focus was far more on how do we make sure
21 this doesn't happen again and trying to learn lessons
22 from the fact that we had high levels of transmission
23 within hospitals. So I am surprised that -- I'd like to
24 think that they weren't focused on money but they were
25 focused on sorting things out so it wouldn't happen

136

1 again.

2 **Q.** I think it's right, isn't it, that the national
3 nosocomial Covid-19 programme, which was about the way
4 that this national framework had been implemented, and
5 it provided an interim report in August 2023 and a final
6 report in 2024, that framework was developed to ensure
7 that local health boards were investigating individual
8 patient deaths from hospital-acquired Covid as a patient
9 safety incident. Why was there no national
10 investigation into the causes of cluster outbreaks in
11 hospitals or the persistent problem of nosocomial
12 transmission in Welsh hospitals?

13 **A.** Well, every single individual case was investigated,
14 18,630-odd. So every, I think, ours was probably more
15 detailed in terms of why things were happening and
16 trying to make sure that we provided -- that we learnt
17 the lessons and there was a huge amount of work done by
18 the Wales National Framework in terms of making sure
19 that they took account of all of the things that they
20 needed to assess, things like PPE and ventilation and
21 bed spacing and visiting rules, so all of that was in
22 the national framework.

23 So I think the investigations could not have been
24 more thorough in terms of the numbers of people, every
25 individual being investigated.

137

1 example. So there were lots of lessons that were
2 learnt, but the fact that we had a follow-up report to
3 find out why they hadn't implemented the recommendations
4 of the first wave is something that probably needs to be
5 explained by the health boards.

6 **Q.** What steps did you take as health minister to try to
7 address the problem of nosocomial transmission in Welsh
8 hospitals?

9 **A.** Well, we were very strict in terms of visiting. So we
10 had to make sure that those kinds of measures were put
11 in place. There was a lot of support in relation to
12 ventilation by the NHS Wales Specialist Estates
13 Services, because I knew that there were lots of people
14 who thought that we needed -- we had a very old estate
15 and that is very difficult so lots of our wards are open
16 wards, they're not individual wards, and obviously it's
17 much more difficult then to stop the spread.

18 Making proper use of PPE, making sure that there
19 was good bed distancing, all of those things were things
20 that were brought up in that Wales National Framework so
21 there were opportunities. People knew what they should
22 be doing but actually if you've got quite an old estate
23 it is much more difficult to control the spread than if
24 you are able to isolate people in individual wards.

25 **Q.** Given that shielding people and those more clinically

139

1 **Q.** But they were investigations into individual cases,
2 weren't they, rather than investigations into the causes
3 of cluster outbreaks within a particular hospital or
4 health board?

5 **A.** Yeah, but it's actually really difficult to get to what
6 exactly is the cause because there are potentially lots
7 of causes and what that group did was to look at all of
8 the potential causes.

9 So to be able to say definitively "This is the
10 precise cause", I think would have been quite difficult.

11 **Q.** You've set out in your witness statement that in May of
12 2022 you were sent and reviewed two public health
13 reports, one of which was called "Lessons learned from
14 nosocomial outbreaks, September 2020-April 2021".

15 I don't think we need to get that up but it shows
16 that nosocomial infection rates in Welsh hospitals were
17 worse in wave 2 than in wave 1, and the conclusion on
18 page 8 of that report was that not all lessons
19 identified at the end of wave 1 were actioned
20 successfully.

21 Were you concerned on reading that that this meant
22 nosocomial transmission in Welsh hospitals may have led
23 to a significant number of preventable deaths in wave 2?

24 **A.** Well, I think it's important to note that some lessons
25 were learnt, the spread of asymptomatic Covid, for

138

1 vulnerable to Covid-19 were going to be at higher risk
2 from contracting Covid infection and also likely to be
3 frequent users of healthcare, were there any efforts
4 made to identify or monitor the number of clinically
5 vulnerable and shielding people who had contracted
6 Covid-19 within healthcare settings? Do you know?

7 **A.** Well, all of that would have been monitored, I assume,
8 on the ward themselves by the people who were
9 responsible for the operational duties within particular
10 wards, so that should have been on their notes.

11 **Q.** You've set out in your witness statement that when the
12 Omicron variant arrived in Wales you were particularly
13 concerned about the impact that this more transmissible
14 variant could have on nosocomial transmission rates.
15 Did you consider at that point that it may be necessary
16 to have a review of IPC measures to ensure that the
17 right protections were in place in hospital settings?

18 **A.** It was something that I discussed with the Chief Medical
19 Officer. We did tighten up some of the rules just
20 before Omicron hit so we actually actioned some things
21 prior, you know, as soon as we knew that Omicron was
22 present in the country. So measures were taken at that
23 point.

24 **Q.** You mention there that one of the measures you focused
25 on in particular was visiting, in relation to trying to

140

1 address nosocomial transmission rates. So if we can
2 look a little at some of the changes that you made to
3 the hospital visiting restrictions when you were
4 minister.

5 You've set out within your statement that you saw
6 it as quite important to allow local healthcare
7 providers to depart from national guidance on visiting
8 in response to local transmission rates although that
9 would necessarily create some inconsistencies in
10 approach across Wales.

11 Can I ask you this, did you consider any specific
12 communication strategies or other measures to try to
13 help explain to affected families why these variations
14 were occurring and particularly at points when wider
15 societal restrictions were lifting but visiting
16 restrictions were remaining in place?

17 **A.** There was -- there was a huge amount going on at this
18 time and obviously the key thing was to communicate with
19 the people who had to implement the rules. So getting
20 the guidance out to the people responsible for
21 implementing was the most important thing. And then,
22 secondly, obviously, to make sure that those who needed
23 to visit understood why.

24 But the fact that there was a kind of national
25 guidance but there was a degree of flexibility locally

141

1 sensitive to it, and learning the lessons from the first
2 wave where we saw those -- that happening in some
3 instances.

4 **Q.** Can I ask you specifically about visiting guidance for
5 maternity services and for pregnant women. I think you
6 were responsible for amendments to the visiting guidance
7 on 9 May 2022. This was the first time that the
8 guidance specified that a birthing partner was not to be
9 counted as a visitor and this was over a year after
10 England had made this distinction between birthing
11 partners or support, birthing support, and visitors in
12 their guidance. And I would like to ask whether you
13 consider the guidance for Wales should have always
14 specified from the first guidance that birthing partners
15 were partners in care and not to be counted as visitors?

16 **A.** If I had my time again, I would definitely have
17 introduced that earlier.

18 **Q.** I think -- thank you. Do you consider now, looking back
19 with the benefit of hindsight, that the visiting
20 restrictions generally in Welsh hospitals, not just in
21 relation to maternity, but that they struck the right
22 balance between the benefits to patients of having
23 visitors and supporters, and reducing the infection
24 risks of visiting? Do you feel that the balance was
25 struck in the right place?

143

1 meant that there was an opportunity for health boards to
2 respond to local circumstances. So, you know, Covid
3 went through in waves around the country and whilst it
4 would have made sense in some areas to tighten things
5 up, and this happened on a number of occasions where
6 health boards just saw a wave coming at them and they
7 tightened everything up, they stopped -- they restricted
8 visiting for a short period and then they loosened up
9 again. And we thought that that approach made sense
10 which gave the flexibility. But obviously there were
11 times when we needed to be sensitive to some specific
12 cases.

13 **Q.** Were you provided with or did you request any advice or
14 supporting information from IPC experts about the
15 contribution to nosocomial transmission rates from
16 visitors coming into hospital, to what extent was it the
17 case that visiting restrictions impacted the number of
18 nosocomial transmissions that seemed to be taking place
19 in Welsh hospitals?

20 **A.** I think we were really aware because of what we'd seen
21 particularly in care settings that sometimes some care
22 workers moving from place to place actually was part of
23 an increased risk. So if that was true for professional
24 workers then the same would obviously be true for people
25 who were not professional workers, so we were already

142

1 **A.** Not when it came to maternity. I think we also
2 discussed, I remember, as a cabinet, people who were
3 perhaps receiving a diagnosis where it was possible that
4 they'd have cancer, that probably we should have been
5 more flexible in that kind of instance as well.

6 So I think there are a few instances where we
7 might have done things slightly differently. But the
8 fact that there was a clear national guidance but the
9 flexibility locally to respond, I think that was
10 probably the right thing at the time.

11 **Q.** If we can move on to a new topic, please.

12 You mention that one of your priorities on coming
13 into office was the recovery of elective services and
14 planned care. When you came into post in May 2021, what
15 did you understand to be the primary reasons for the
16 backlog of patients awaiting diagnosis and treatment for
17 conditions other than Covid-19, and what were the main
18 obstacles to recovery of elective care at that time?

19 **A.** Well, we've been very clear that the focus should have
20 been on urgent cases, on cancer, and there was huge --
21 and non-emergency services obviously. And in Wales you
22 have a situation where we don't have many major cities,
23 so it was really difficult to have planned care separate
24 from emergency care. And so emergency care knocked out
25 planned care quite regularly, and that clearly caused

144

1 a problem.

2 But I think, you know, there was lots going on in
3 health at the time, it wasn't just about planned care.
4 In Wales we have 2 million contacts a month, in
5 a population of 3 million people, in the health service.
6 The demand on the service is enormous. And so you have
7 to remember the context of having to keep all of that
8 going at the same time as well.

9 **Q.** For winter 2021-2022, the winter plan that you announced
10 for that period was clear that, due to that projected
11 increased pressure on the NHS, the number of patients
12 receiving planned care would reduce. You said this:

13 "On planned care, we will be straight with the
14 public and explain that it will be tough to work
15 through the high numbers on our waiting lists over the
16 winter, and we may need to flex the system and reduce
17 the numbers receiving planned care treatment if the
18 pressure on the system continues to mount."

19 Was there any consideration given to using field
20 hospitals or independent sector facilities as elective
21 hubs to enable elective care to continue through that
22 winter?

23 **A.** Well, when it came to field hospitals, the issue with
24 field hospitals wasn't the beds it was having the staff
25 to be able to operate the beds. So the problem doesn't

145

1 Can I ask whether you took any steps as health
2 minister to address that health inequality in relation
3 to elective care specifically?

4 **A.** Well, I mean, that wasn't anything new. The demands --
5 you know, we have an older, sicker, poorer population,
6 and it is concentrated in various parts of the country.
7 So we went into the pandemic with people in those areas
8 facing longer waiting lists anyway.

9 I think the other thing to note is, for example,
10 it's quite difficult to recruit sometimes into some of
11 those areas, particularly into rural areas, so --
12 you know, people -- a lot of medics want to be in
13 cities, and that makes it much more difficult.

14 And I think the other thing that's worth noting is
15 that the challenges of delayed transfers occur, and that
16 was becoming an increasing problem, particularly if you
17 can't -- if you can't separate out planned care from
18 emergency care, like you can in big cities, where you
19 have two hospitals in a similar area, that is really
20 challenging. So we are developing surgical hubs now but
21 they have to be developed on -- very much on a regional
22 basis rather than it -- within health boards, because
23 there's just -- you know, we just don't have the
24 population base to hold those.

25 So those have been developed since, are being

147

1 go away just because you can provide field hospitals,
2 you still have to provide the staff. So that was the
3 problem there.

4 When it came to the private sector, there's got to
5 be an understanding of the number of beds in the private
6 sector in Wales. We have 172 beds in the entire private
7 sector in Wales. So whilst in England I think they used
8 about -- they cleared about 18% of their waiting lists
9 through the private sector, we had 172 beds. So we
10 even -- and we did use the private sector, but obviously
11 there's not much to use there, and we did actually use
12 some private capacity in England as well. So it's not
13 as if we didn't do it, it's just that actually the
14 provision is a long way from Wales, and that definitely
15 made a difference.

16 **Q.** Can I ask you about the issue of health inequalities in
17 terms of elective care. You refer in your witness
18 statement to an evidence paper prepared for the Health
19 and Social Care Committee investigation into the impact
20 of the waiting times backlog on people in Wales. That
21 paper I think was prepared in February of 2022, and it
22 noted that investment to increase capacity had not been
23 provided until 2021, and also that deprived areas faced
24 disproportionately large waiting lists per head of
25 population compared with the least deprived areas.

146

1 developed, but it's a new approach because you need it
2 to happen on a regional basis and that is something
3 fairly new in our system.

4 **Q.** The Inquiry has heard from two experts in orthopaedic
5 surgery, Professor Metcalfe and Ms Chloe Scott, and
6 I think a transcript of their evidence has been provided
7 to you. They explain to the Inquiry that the delivery
8 of restoration of elective care in Wales was
9 significantly delayed compared to what was happening in
10 England, and Professor Metcalfe told the Inquiry that
11 the first guidance document on recovery of elective care
12 was -- orthopaedic care was released in 2022, and the
13 Welsh guidance document was much more vague than the
14 NHS England equivalent, and it, importantly, was not
15 linked to any financial incentives. And consequently,
16 treatment delays in Wales were, in the words of
17 Professor Metcalfe, absolutely huge.

18 Do you think that the Welsh Government should have
19 planned to recover elective care sooner in the pandemic
20 and taken steps to incentivise the local health boards
21 who were able to restore elective services?

22 **A.** I do think it would have been better to have perhaps
23 come up with the plan sooner. I'm not sure if it could
24 have been implemented sooner with the pressures that the
25 system was under.

148

1 So our system is not one, currently, that is
 2 driven by financial incentives. There's
 3 an understanding in some quarters that that perhaps
 4 sometimes leads to unintended consequences, but I think
 5 also that there was a need for not just us to be more
 6 deliberate in terms of ensuring that we knew exactly
 7 what was going on within these orthopaedic hubs, but,
 8 more than that, the health boards needed to know what
 9 was going on. So, again, I did one of my unplanned
 10 visits to an orthopaedic hub, on a Thursday afternoon,
 11 and I found there were 13 surgeons not working. They
 12 weren't there. So, you know, the monitoring, the
 13 management was not happening in the way that it should
 14 have been happening.

15 **Q.** That brings me on to my next question, which was whether
 16 the Welsh Government monitored elective or planned care
 17 during the pandemic. Was it counted separately, if
 18 I can put it in that way? Was there a monitoring of how
 19 much activity was going on?

20 **A.** Well, I initiated very, very careful monthly monitoring,
 21 where I asked for details on what was going on, how long
 22 the waiting lists were coming -- how quickly the waiting
 23 lists were coming down, particularly for those longest
 24 waiters. So, you know, I personally got really involved
 25 in monitoring what was happening on a monthly basis in

149

1 **A.** They were not.

2 **LADY HALLETT:** Whatever the explanation was, it was not
 3 a satisfactory one?

4 **A.** It was not a satisfactory one.

5 I'm happy to send, perhaps, the letter that
 6 I wrote, to you. It might be of interest.

7 **MS NIELD:** If we can move on then to some questions, please,
 8 about shielding. I think it's right that the shielding
 9 programme in Wales was paused in March of 2021, so it
 10 was paused when you came into post as Minister for
 11 Health and Social Services. And, in fact, it wasn't
 12 reinstated during your tenure as minister, I think
 13 that's right, but I think there were, certainly at least
 14 two occasions, when you received advice from the Chief
 15 Medical Officer for Wales as to the position of people
 16 on the shielded patients list and you were given the --
 17 given some advice or some options about either
 18 reinstating the shielded patients list or, indeed,
 19 closing the shielded patients list.

20 I think in July of 2021, in the light of the
 21 planned relaxations for the general community, in terms
 22 of Covid restrictions being relaxed, the Chief Medical
 23 Officer advised you that the shielding programme should
 24 not be reinstated but he intended to write to the
 25 clinically extremely vulnerable advising them to take

151

1 terms of the planned care programme, because it wasn't
 2 going in the way that I'd hoped.

3 **Q.** Do you think that future pandemic plans should include
 4 a specific strategy for the continuation or at least the
 5 prompt recovery of elective care?

6 **A.** I think having a plan is easier than actually making it
 7 happen, particularly if you can't separate out planned
 8 care from emergency care. And that was one of the real
 9 difficulties for us. You know, we didn't have the
 10 private hospitals to the extent they did elsewhere. We
 11 didn't have the orthopaedic hubs, although, you know,
 12 the orthopaedic surgeons gave really clear direction in
 13 terms of what they wanted to happen. But again,
 14 you know, I visited the -- one of the few orthopaedic
 15 hubs that we had, and they weren't working. So, you
 16 know, I do think people have to be held to account
 17 within a system.

18 **LADY HALLETT:** Did you discover why they weren't working?
 19 Forgive me, I'm losing my voice.

20 **A.** I did -- I was given an explanation.

21 **LADY HALLETT:** It sounds as if you didn't accept it.

22 **A.** It wasn't what I expected to see and I took steps
 23 afterwards to make it clear that things had to change.

24 **LADY HALLETT:** So it wasn't that they were off sick or
 25 anything?

150

1 extra care to minimise their exposure to the infection,
 2 to meet outside where possible, keep contacts to
 3 a minimum, and to continue social distancing.

4 Why did you not consider it advisable to reinstate
 5 shielding at that point if the lifting of restrictions
 6 in the general community may place those people at
 7 greater risk?

8 **A.** Well, because by this point they'd been vaccinated so
 9 they had a degree of protection and this was really just
 10 a precaution for them to give them more confidence to
 11 know, look, actually, we know that things are going to
 12 open up, that there is a potential for it to spread.
 13 This was happening in the summer, so it was less likely
 14 to spread than in the winter, but we just wanted to give
 15 them confidence and to give them reassurance that these
 16 are the measures you can take if you do want to protect
 17 yourself, because it wasn't a one-way thing. There were
 18 some people who were really concerned because of their
 19 vulnerable and they needed to be given that additional
 20 guidance in terms of what might help them to avoid
 21 contracting the virus despite being vaccinated.

22 **Q.** Were the steps set out by the Chief Medical Officer that
 23 I've outlined not effectively advising those who had
 24 been on the shielding list to continue to shield but
 25 simply without any government support to do so?

152

1 **A.** No, we weren't advising them to continue to shield, we
 2 were giving them tips on -- the Chief Medical Officer
 3 was giving them tips on how to avoid obvious things,
 4 like, don't go to a disco, just kind of a common-sense
 5 approach, I think, just reminding them of how mixing
 6 with people, in particular in close-set environments was
 7 likely to increase their risk of contracting the virus.

8 **Q.** I think it's right that in December of 2021 Rebecca
 9 Evans, a member of Senedd, wrote to you with a request
 10 to reinstate the shielding programme in the light of the
 11 concerns about the emergence of the Omicron variant.
 12 And in that letter she stated that vaccination is only
 13 effective in 40% of the clinically extremely vulnerable.
 14 I think on that occasion the Chief Medical Officer of
 15 Wales again wrote to those on the shielded patient list
 16 reiterating the advice to take extra precautions but the
 17 shielding programme was not reinstated at that point.

18 Did you consider whether this might be, with the
 19 emergence of the Omicron variant in the middle of winter
 20 2021, that this might be a time when it would be
 21 appropriate to reinstate the shielding programme?

22 **A.** I got advice from the Chief Medical Officer. I think
 23 it's probably worth noting at the time we weren't sure
 24 how Omicron would affect people. I think there was
 25 a degree of confidence that the vaccine would be able to

153

1 ascertain the views of the clinically extremely
 2 vulnerable in terms of the impact on them of being asked
 3 to shield or indeed of pausing the shielding programme?

4 **A.** Well, before becoming health minister, I was the
 5 minister for mental health, and we knew that there were
 6 a lot of people who had been suffering, particularly
 7 younger people, as a result of the need for them to
 8 self-isolate. So it was a question of balancing.

9 In terms of the clinically extremely vulnerable,
 10 then that was -- the CMO would have been looking into
 11 that.

12 **Q.** Can we come on, please, to look at Long Covid.
 13 You've explained in your witness statement that by
 14 the time you were appointed Minister for Health and
 15 Social Services, there were established systems and
 16 processes already in place across the NHS in Wales for
 17 the management of Long Covid. And you've explained that
 18 you received advice in June of 2021 that funding of
 19 £5 million was required to support the expansion and
 20 development of primary and community services for those
 21 recovering from the effects of Covid-19.

22 Do you think that the funding should have been
 23 made available earlier than June of 2021?

24 **A.** Look, I can only speak for myself. I was appointed in
 25 May. It was an area where I felt we probably needed to

155

1 withstand Omicron but the letter was, once again, to
 2 give them reassurance and by now, of course, we had the
 3 retrovirals as well that could be given if they did
 4 contract the virus.

5 **Q.** In the light of the concerns that those who were
 6 severely immunosuppressed and may not be able to take
 7 the vaccine or the vaccine may be less effective in
 8 those people, was there any consideration given to
 9 extending the shielding programme with all the
 10 protections that that had, for example access to
 11 Statutory Sick Pay and so on, for those -- for that
 12 cohort within the shielded patient list, so those who
 13 were severely immunosuppressed?

14 **A.** It was considered by the Chief Medical Officer.
 15 Of course, by now, it had already been dismantled in
 16 England so, you know, we thought that it made sense for
 17 us to again give them advice on how they should protect
 18 themselves.

19 **Q.** You've referred in your witness statement to having to
 20 balance the benefits of shielding against the
 21 disbenefits such as social isolation, and so on, when
 22 you were deciding whether to reinstate the programme.
 23 Beyond the concerns of individual constituents being
 24 brought to your attention by members of the Senedd, did
 25 you seek to ascertain the views or ask your officials to

154

1 do a little bit more work, and within a month we had
 2 a new programme. We had £5 million in that programme.

3 I think I was really sensitive to it because my
 4 brother-in-law had been suffering with it, so I was
 5 probably more attuned to it and thought that we needed
 6 to do a bit more work in that space.

7 **Q.** In terms of the model of clinical support for people
 8 with Long Covid in Wales, I think you've been provided
 9 with the Public Health Wales International Horizon
 10 Scanning Report which was published in May of 2021,
 11 which advised that the multidisciplinary approach to
 12 assessment and management and patient involvement are
 13 all instrumental in addressing Long Covid.

14 Would you agree that the existing system that was
 15 in place when you became minister in May 2021 was not
 16 providing a multidisciplinary approach to assessment and
 17 management of Long Covid?

18 **A.** I think we were still trying to work out what Long Covid
 19 was. One of the first things I did was to visit
 20 a multidisciplinary -- it wasn't a clinic, it was being
 21 carried out in a sports centre where several different
 22 therapists were brought together, and in fact I visited
 23 two of those as the project continued. So that
 24 multidisciplinary process, I don't know what was there
 25 before but it was certainly being developed very quickly

156

1 after my appointment.

2 **Q.** I think that the programme that was developed, the

3 Adferiad programme that was developed, was reviewed

4 every six months and the local health boards were

5 required to submit reports on that, is that correct?

6 **A.** Mm-hm.

7 **Q.** I think the first report was in January 2022, which

8 you've summarised in your report.

9 Is it right that that report also showed that some

10 local health boards did not start offering services

11 until December of 2021, and did you have any concerns

12 that there seemed to be inconsistency across the local

13 health boards in Wales as to the services that were

14 being provided for people with Long Covid?

15 **A.** First of all, in terms of Adferiad, "adferiad" means

16 recovery in Welsh. Long Covid, we were all learning

17 about Long Covid, and I was clear if we can start a new

18 programme on a condition that people don't know much

19 about, we should make sure that we're reviewing it all

20 the time, because the science was changing, the evidence

21 was changing, we needed to keep up. So that was

22 absolutely central to the programme, is that we had to

23 just keep on updating it and finding out was it -- was

24 it addressing the issues, was it being effective, and

25 was it keeping up with the science. And at the same

157

1 based. It is a model that is in keeping with our

2 strategic plan, A Healthier Wales. Very interesting to

3 see that Lord Darzi is now recommending that's what

4 should happen in England. And so we needed to provide

5 a model that worked within the structures that we have

6 within Wales, and those structures are always to try to

7 give support as close as you can to where people live.

8 So there was a mechanism, via a GP -- we made sure

9 everybody knew what the pathway should be -- via the GP,

10 into the multidisciplinary teams, and then on, if

11 necessary, to specialist support services. And what we

12 found when we assessed the programme was that there was

13 a very high degree of satisfaction from the people who

14 used the services. I think 87% of people said that they

15 would recommend it and that only about 3.5% of people

16 were referred on to those -- to secondary care,

17 effectively, who needed that real specialist support.

18 **Q.** I think the January 2022 report referred to those

19 results from the CEDAR evaluation study that you've

20 referred to. Were you aware that that CEDAR evaluation

21 study, there was a survey of patients, also included

22 some negative feedback? Nearly 30% of existing service

23 users rated the Long Covid services in Wales as average

24 or below and that some existing users felt that

25 treatment was too generic and the service was not

159

1 time we put about -- I think about 700,000 into research

2 on Long Covid as well.

3 But just in terms of the money and when it was

4 being influenced, this came in in June. The money

5 didn't hit the ground until, you know, July, and so,

6 it -- you know, it's not something you can switch on

7 overnight if you've got multidisciplinary teams that you

8 need to pull together.

9 So I'm sure that some were further ahead prior to

10 the programme.

11 **Q.** The Inquiry has heard from two specialists in

12 Long Covid, Professors Brightling and Evans. And again,

13 I think transcripts of their evidence has been provided

14 to you.

15 Professors Brightling and Evans told the Inquiry

16 that the gold standard for Long Covid care is

17 a multidisciplinary team clinic which is a one-stop shop

18 for patients, and that that hadn't been adopted in

19 Wales, and furthermore that the variation between local

20 health boards in the services for Long Covid was

21 a disservice to patients in Wales.

22 Was any consideration given to adopting Long Covid

23 clinics as evidence emerged of their clinical and

24 cost-effectiveness?

25 **A.** Well, the way NHS is organised is very much community

158

1 helpful overall?

2 **A.** Well, you obviously can work out if you've got,

3 you know, 83% who would recommend it to their friends --

4 or 70% of people who are satisfied that there's 30% who

5 had not satisfied. So, I mean, there's still people

6 suffering with Long Covid today and, you know, they

7 haven't had the answers that -- and the results that

8 they'd hoped. So, you know, I can see why they would

9 feel frustrated. I'd be surprised if you'd get to 100%

10 satisfaction with specialised Covid clinics.

11 **Q.** If we can move on, please, to look at primary care and

12 the changes made in primary care during the pandemic.

13 There was a perception that people could not get

14 an appointment to see their GP and that face-to-face

15 appointments had been stopped entirely. What do you

16 think caused that perception and could more have been

17 done to dispel that perception?

18 **A.** I think at the beginning, you know, people thought

19 everything had shut down and there was an opportunity --

20 I was married to a GP -- I am married to a GP, who was

21 on the front line every single day, so I was very aware

22 that he was going into work, as were all of his

23 colleagues. That perhaps wasn't something that was

24 recognised by the rest of the public. But we made it

25 very clear that, you know, GP surgeries were open,

160

1 albeit not in the usual way. So, you know, for a long
2 time they weren't doing face to face but they were doing
3 online consultations, they were doing telephone
4 consultations.

5 And one of the things we did in Wales is to make
6 sure we continued with that understanding that actually
7 you're not going to get a face-to-face appointment with
8 a GP every time you ask for one because actually the
9 system worked quite well for other people.

10 And since then we've changed the GP contract in
11 Wales so that we've got rid of lots of the issues that
12 exist elsewhere and existed before because we've changed
13 that contract.

14 **Q.** Did you take any steps as health minister to ensure that
15 GP surgeries in Wales were making face-to-face
16 appointments available for those patients who needed
17 them?

18 **A.** So it was up to the clinicians, to the GPs themselves to
19 determine and to do the triaging in terms of who needed
20 to come in. I don't think it would be appropriate for
21 a politician to say, you know, these are the people who
22 need to come in, these are the people who need to be
23 seen. You know, that is the job of a clinician, and
24 they had to do that risk assessment themselves.

25 **Q.** Do you think the Welsh Government made it clear enough
161

1 Given that the report of Mr Hedges was clearly
2 that that All Wales DNACPR policy had not been complied
3 with, did you obtain any further details from him to
4 investigate where and how those specific incidents that
5 he was complaining about had occurred?

6 **A.** I can't remember if I -- I can't remember. I'm sure
7 that we would have followed that up but I'd like to have
8 the opportunity just to make sure that that is what
9 happened. Because I was -- I know I was really
10 concerned about it and concerned about any instance
11 where there was a suggestion that that happened.
12 Because we had a very clear policy on this, so clearly
13 if that was happening they were not following the
14 guidance that we put in place. And we had had a report
15 by Health Inspectorate Wales who had done a sample
16 review and they didn't raise any issues at the time and
17 I know there was kind of -- they were very keen to make
18 sure there was personalised and compassionate
19 communication.

20 **Q.** Can you help us, please, with when that Health
21 Inspectorate Wales sample review took place?
22 The Inquiry has heard that there was a review that was
23 announced, I think, in October of 2023. Was this
24 a review that took place during the pandemic?

25 **A.** I think there was one that took -- if you wouldn't mind,
163

1 to GPs that they had to continue to offer those
2 face-to-face services for some patients?

3 **A.** I think we did make it clear. We're very aware in Welsh
4 Government of the equalities issues and the difficulties
5 perhaps, in particular, of older people who perhaps
6 found it difficult to have some of those conversations
7 on the telephone or not face to face. So that should
8 always have been a service that was available.

9 I'm not sure if I'm aware of any who didn't
10 provide that but they are the ones who had to determine
11 who should come in and who shouldn't.

12 **Q.** I'd like to move on, please, if we may, to a new topic:
13 DNACPR notices and concerns about blanket or
14 inappropriate application of those notices.

15 I think it's right that on 1 February 2022 you
16 were informed by Mike Hedges, a member of Senedd -- this
17 is at paragraph 292 of your witness statement.

18 Mr Hedges was informing you of the concerns of the Covid
19 bereaved group that DNACPR notices had been issued for
20 their loved ones without any discussion with the
21 relatives. And you made a written response, I think, to
22 Mr Hedges which referred to the All Wales DNACPR policy
23 and the fact that that policy explained there should be,
24 always, consultation with those concerned when a DNACPR
25 notice was being considered.
162

1 I'd like to check that rather than give you something
2 that will mislead you.

3 **Q.** Thank you.

4 You've also referred in your witness statement to
5 another written question from a member of Senedd,
6 Russell George a couple of months later, in April of
7 2022. Again, concerns about DNACPR.

8 And can we have a look at your written response,
9 INQ000480092. And you respond in this way:

10 "I am aware that there have been some high
11 profile media reports of blanket DNACPRs being applied
12 and have been notified of some isolated incidents
13 where it is alleged that DNACPR policy has not been
14 followed."

15 You go on in your witness statement to explain
16 that you're referring to the incidents that triggered
17 the letter from the CMO and the CNO of Wales.

18 You said that:

19 "The Welsh Government takes these allegations
20 very seriously and in each case has acted promptly to
21 investigate and seek confirmation of the governance
22 and assurance processes in place within the relevant
23 health board to ensure these decisions are taken in
24 line with extant clinical guidance."

25 Wasn't the issue here not that there wasn't any
164

1 appropriate policy or guidance in place but that those
2 policies were not being followed by individual
3 clinicians? Rather than seeking assurance of their
4 governance and assurance processes, why didn't the Welsh
5 Government, or you as minister, ensure that there was
6 a review of DNACPR decisions that had been made?

7 **A.** I think that letter demonstrates that we were chasing
8 down every case that we heard about and clearly we
9 expect people to follow our governance and our guidance.
10 One of the things we did was to introduce a Wales
11 competency framework because part of the issue was just
12 to make sure people knew what they should be doing, so
13 we made sure that clinicians followed a competency
14 framework so that they knew how to fill out DNACPR forms
15 and to make sure that they did everything appropriately
16 including, in particular, making sure that they had
17 compassionate communication not just with the person
18 involved but also their families.

19 And then the other thing that we did was to
20 introduce a mortality review framework so -- and within
21 that there was a thematic review in relation to DNACPR,
22 and there was an action plan that had to be followed
23 afterwards.

24 So these were kind of actions: right, here is the
25 guidance that looks like you're not all following. This

165

1 and, you know, if you can fill in forms in a common way
2 then that would make sense as well. As long as we all
3 agree with the policy. So, you know, as I suggested
4 that we had our own clinical policy -- so, you know,
5 you'd have to make sure that the policies were in
6 keeping before you started to do that.

7 **MS NIELD:** Thank you very much. That's the end of that
8 topic. I wonder if that's a suitable point.

9 **LADY HALLETT:** Perfect timing. 3.25.

10 (3.10 pm)

(A short break)

12 (3.25 pm)

13 **LADY HALLETT:** Ms Nield.

14 **MS NIELD:** Baroness Morgan, can we look, please, at the
15 actions that you took to address problems in the
16 ambulance sector during your time as minister. I think
17 it's right to say there were persistent issues with
18 excessive ambulance response times throughout 2021 and
19 2022 and those problems were exacerbated by staff
20 shortages due to high absence rates and lengthy handover
21 delays at hospital; is that correct?

22 **A.** That's correct.

23 **Q.** I think in June of 2021, so after you'd been in post for
24 about a month, having been provided with an interim
25 report of the ministerial Ambulance Availability

167

1 is what we expect you to do as a result. So there was
2 a follow-up.

3 **Q.** And who was the competency framework made available to?

4 **A.** That was to the NHS clinicians and there was a whole
5 training programme that happened with that.

6 **Q.** The Inquiry has heard from the president or former
7 president of the Resuscitation Council UK who had
8 developed the ReSPECT form which is a process used in
9 parts of England and Scotland to note advanced care
10 plans, including DNACPR wishes of patients, and
11 Professor Wyllie told the Inquiry that he considered it
12 would be beneficial if there was one standard advanced
13 care planning form which would include wishes around
14 CPR. If there was one form in use across the UK,
15 particularly given the amount of movement that exists
16 between the countries of the UK, would you agree with
17 that or do you think there are compelling reasons why
18 Welsh patients should have a different process for
19 recording their views?

20 **A.** I think there would be huge advantages to us having
21 a common digital framework across the whole of the
22 United Kingdom. We're all in different places on
23 different things so this is not so straightforward to
24 make that happen but in an ideal world I probably would
25 suggest we need to try to collect data in a common way,

166

1 Taskforce, you requested a meeting with the Emergency
2 Ambulance Services Committee, and you noted in that
3 meeting that the national target for immediately
4 life-threatening calls, red calls, had not been achieved
5 since July of 2020, and that a move was needed -- these
6 are your words:

7 "... a move was needed from review and diagnosis
8 to radical and rapid focus on delivery of actions that
9 are known to make a difference to patients."

10 And in that meeting you set out a number of
11 expectations for the health board executives, for the
12 Welsh Ambulance Services Trust, and for the Chief
13 Ambulance Services Commissioner to develop a plan to
14 address these issues. Would it be right to say that it
15 appeared to you at this point that the ambulance
16 committee members had been ineffective and slow to
17 address the evident problems in ambulance response
18 times?

19 **A.** I'm not sure if it's fair to say that I'd only been in
20 post for a month but what I can say is that I thought
21 the time for talking was over and it was time for
22 action, and so that's why when they asked me if they
23 could have a 12-month extension on the group I said: no,
24 give me a delivery plan and close this group down and
25 get on with the job.

168

1 So I was just responding to what I saw in front of
 2 me. I don't know what happened before.
 3 **LADY HALLETT:** How refreshing.
 4 **MS NIELD:** You go on to set out in your witness statement
 5 that unfortunately ambulance performance continued to
 6 decline into October of 2021, and you received, I think,
 7 a ministerial advice on 19 November 2021 requesting that
 8 you agree £5 million of additional funding to the
 9 ambulance sector, which you agreed I think on
 10 22 November 2021. And that funding was for the
 11 recruitment of more frontline staff, clinical support
 12 desk staff, additional non-emergency transfer vehicles
 13 and support for a make-ready depot for the ambulance
 14 crews to use; is that correct?
 15 **A.** That is correct.
 16 **Q.** I think in addition to that £5 million that you had
 17 agreed for the Welsh Ambulance Services Trust
 18 in November of 2021, during the autumn and winter of
 19 2021 into 2022 you were also asked to approve a series
 20 of requests for military aid to the civil authorities,
 21 MACA requests, for additional drivers to assist the
 22 Welsh Ambulance Services Trust. And I think the first
 23 of those requests came in September of 2021.
 24 Can we have a look, please, at the ministerial
 25 advice supporting that request.
 169

1 the tasks. Other options, such as commercial
 2 alternatives, have been explored."
 3 And finally:
 4 "If action is not taken quickly there is
 5 a significant risk to life."
 6 So, the necessity of considering this additional
 7 support was made very clear to you and the consequences
 8 of the situation continuing as it was were made very
 9 clear there.
 10 I think it's right that, having received that
 11 advice, on 24 September 2024 the director general,
 12 Andrew Goodall, advised that rather than the 251 drivers
 13 that had been requested by WAST, just 100 drivers should
 14 be provided.
 15 If we can go, please, to his email to you setting
 16 out that advice. He says this in the middle of that
 17 paragraph:
 18 "Personally I feel that an offer of around
 19 100 military personnel is more likely, more practical to
 20 be delivered would be higher than we had before, and
 21 would be equivalent in numbers to similar proposals in
 22 Scotland and NI. Costs obviously would be lower
 23 accordingly."
 24 And I think that you accepted that advice from
 25 Andrew Goodall, and 110 drivers were provided for
 171

1 It's INQ000480061.
 2 We can see here at point 4 that:
 3 "... data indicates that [the Welsh Ambulance
 4 Services Trust] should increase its emergency ambulance
 5 capacity to 150% in order to meet predicted demand."
 6 Which does not include predicted demand from
 7 seasonal flu. And:
 8 "The Welsh Government have committed to continue
 9 with elective surgery over the winter period to meet the
 10 backlog from ... COVID-19."
 11 I think over the page, on page 2, 251 drivers were
 12 requested at that point to drive Welsh Ambulance
 13 Services' ambulances from 15 October to 31 March 2022.
 14 That was an equivalent of an additional 42 emergency
 15 ambulance crews across the week.
 16 And if we can go to page 3, please, in support of
 17 that request, at point 15 it's noted that:
 18 "It is necessary to take this action to reduce
 19 patient harm and suffering as a direct consequence of
 20 delayed attendance to in-community cases/calls for
 21 emergency [ambulance] response creating significant risk
 22 to life."
 23 And the penultimate bullet point there:
 24 "The Welsh Government and wider public services
 25 lack the necessary capability and capacity to fulfil
 170

1 a period of six weeks.
 2 Why did you accept this advice from the
 3 director general to offer fewer than half of the
 4 requested number of drivers in the light of the very
 5 clear advice from the Welsh Ambulance Services Trust
 6 that additional capacity was required to save lives in
 7 Wales?
 8 **A.** Well, that was just the first tranche, and later on we
 9 brought on about 250. So by the end of the winter
 10 period there were far more than the 110 that were first
 11 asked for.
 12 **Q.** I think it's right that an additional request was made,
 13 I think on 17 November 2021, a further request for
 14 251 drivers --
 15 **A.** Yeah.
 16 **Q.** -- to support the Welsh Ambulance Services Trust, and
 17 you agreed that request and you were informed, I think
 18 on 15 December, that the authorisation had been granted
 19 for the 251 drivers until the end of March of 2022.
 20 If the original September request for 251 drivers
 21 had been granted in full, would that not have avoided
 22 the need for the second MACA request that was made
 23 in November?
 24 **A.** Well, all I know is there was a 10% reduction from the
 25 first -- in terms of impact on the first 100 that we got
 172

1 in. But obviously -- I think we were -- the difference
2 is we were building up into a more intensive period so
3 whilst in October you may need a certain number, by the
4 time you get to February you need more, so that kind of
5 stepping up makes sense to me.

6 **Q.** Did lack of ambulance capacity continue to be an issue
7 throughout the third wave of the pandemic or did this
8 seem to have solved the problem?

9 **A.** So, well, it is really difficult because -- well, first
10 of all, there was a capacity issue and so this was going
11 alongside the fact that I gave them 5 million extra to
12 go and recruit more ambulance drivers, we were getting
13 100 new ambulance workers in but you can't switch them
14 on, you need to train them up, so the reason why we
15 needed these in was to prepare those new permanent
16 ambulance workers so that was really helpful.

17 Part of the issue here -- it's not just all about
18 the ambulance service, it's about things like delayed
19 transfers of care and, you know, them sitting outside
20 the hospitals for a long time because you can't get
21 people through the back door, so at the same time at
22 this was happening I was doing huge amount of work on
23 how do you get the flow through the system. We created
24 an extra 770 community beds that winter in order to help
25 the flow. So you can't look at this in isolation to the

173

1 numbers they were on about 13.5% sickness rates in
2 the February. So if we hadn't had the military in, and
3 the 100 new ambulance workers were only just coming
4 online, it would have been really difficult.

5 **Q.** I'm asked to ask you what, if any, consideration was
6 given to filling the gap in the ambulance service by
7 seeking to use the independent ambulance sector who were
8 used nationwide in England to provide support to
9 existing NHS ambulance services in Wales. Was that
10 a possibility?

11 **A.** Well, we did use St John Ambulance and we -- so we did,
12 but they can't do some of the emergency work that
13 obviously the core ambulance group can do.

14 **Q.** Thank you.

15 Turning now, if I may, to staff, NHS staff issues.
16 Was there any means you were able, as minister, to gain
17 an understanding about the impact of the pandemic on the
18 health, including the mental health and well-being of
19 NHS staff and healthcare workers?

20 **A.** There was. I'd just come from the role of being
21 responsible for mental health. There was a particular
22 focus on supporting people in the NHS and we had a whole
23 programme of work. We put £1 million into supporting
24 them through Health for Health Professionals support
25 network that turned later into Canopi. So there was

175

1 other things that were going on.

2 And also, don't forget, there was an issue of the
3 number of people who were absent in terms of work from
4 the ambulance service as well.

5 **Q.** I think you note in your witness statement that staff
6 sickness was a persistent problem in the ambulance
7 sector and that the ambulance workforce had markedly
8 higher absence rates than other sectors of the
9 healthcare workforce. Were you able to ascertain the
10 reasons why that sector was particularly badly affected?

11 **A.** I met with the ambulance service on a monthly basis and
12 went through these figures. I was breathing down their
13 necks on this because I knew it would be a big
14 issue over winter, and I asked them consistently: what
15 are you doing about this? Why are the rates so high?
16 And I guess some of it was because they were more
17 exposed, they were in the vehicles with people who had
18 Covid, and whatever. So that had an impact.

19 I think some of it was because they were
20 disillusioned because they were waiting for hours on end
21 outside so, you know, there was an issue there.

22 So they had to do a lot of work and it did come
23 down but I was asking them consistently, what were they
24 doing about it, and how were they addressing this. So,
25 you know, they did come down, but if you look at the

174

1 definitely an awareness that they needed support and we
2 put that support in place.

3 So, you know, as I say, I visited the frontline
4 quite a lot and I was very moved and touched by it, so
5 recognising that people needed support when they're
6 under the kind of pressure that they were was absolutely
7 central to the way that we needed to deal with this
8 pandemic.

9 **Q.** In terms of risk assessments for NHS staff, workforce
10 risk assessments, at paragraph 69 of your witness
11 statement you refer to the September 2021 report of the
12 First Minister's black and minority ethnic Covid-19
13 advisory group which set out the progress that had been
14 made in developing the all-Wales NHS risk assessment
15 tool.

16 Page 9 of that document showed that the Velindre
17 Trust had the highest rate of risk assessing its staff,
18 with 71% of its staff who had received a risk assessment
19 and three other trusts, boards rather, were assessed as
20 having over 60% compliance. Did you think that that was
21 an acceptable level of compliance and do you think it
22 should have been mandatory for all staff to be risk
23 assessed by the local health board where they were
24 employed?

25 **A.** I think the black, Asian and minority ethnic risk

176

1 assessment tool was in place before I became the health
2 minister, so I can't speak for what was going on then
3 but obviously, in an ideal world, you'd want everybody
4 to have a risk assessment.

5 **Q.** Do you think it would have been more effective to ensure
6 or to require the local health boards to risk assess all
7 their staff and to make it mandatory rather than
8 an optional tool that they could use if they wished to?

9 **A.** I don't know about that because I was just thinking
10 about all of the other pressures they were under. But
11 I think we were particularly concerned with the black,
12 Asian and minority ethnic group because there seemed to
13 be a much higher incidence in terms of Covid and
14 critical care and all of those issues, so we wanted to
15 make sure that that support was in place, particularly
16 for those frontline workers and that they should
17 definitely be considered in that risk assessment tool.

18 But I guess it depends where in the system they
19 are. So, you know, if you're in an office the risk
20 assessment is probably not as essential as if you're on
21 the front line in an emergency department.

22 **Q.** From your engagement with healthcare workers during the
23 pandemic, do you think that the Welsh Government did
24 enough to address inequalities for black, Asian and
25 minority ethnic healthcare workers?

177

1 current Director General of the Health and Social
2 Services Group, Judith Paget, that the Welsh Government
3 or NHS Wales has not produced one single overarching
4 report into the pandemic response of the Welsh
5 healthcare system as, for example, has been done within
6 NHS England. Would it have been useful for you, do you
7 think as health minister, to have undertaken a "lessons
8 learned" review across the healthcare system or to pull
9 together those pieces of work that had been done in
10 order to reflect upon what lessons can be learned and
11 taken forward for a future pandemic?

12 **A.** Well, we were doing a lot of lessons learned as we were
13 going on, that's what we were trying to do, in between
14 the various waves so that we could -- it could make
15 a difference as things were happening. I mean, we have
16 had a lot of reports done in terms of how we managed
17 Covid, what could have been done better, and you're
18 right in a sense we haven't pulled them all together.
19 I guess this Inquiry will be very helpful in terms of
20 pulling all those pieces together.

21 And one of the things that I'm really keen to do
22 is to have that comparison, you know. It's quite
23 difficult to make an assessment sitting in one place.
24 I think it's really useful to have a Covid Inquiry to
25 make those comparisons what worked well in different

179

1 **A.** I think the establishment of that group -- as I said,
2 that happened before my time. There was a real
3 sensitivity to it. It was something we discussed very
4 frequently in Cabinet meetings. So I think -- I'm not
5 sure what more we could have done. What we've tried to
6 do is to build on that and now we have a very
7 comprehensive anti-racism action plan that is following
8 through as a result of that because it wasn't just about
9 people in the NHS workforce, there's a broader issue in
10 society.

11 **Q.** The Inquiry has heard that although the local health
12 boards in Wales did record deaths of healthcare workers
13 from Covid-19, and kept statistics on that, the Welsh
14 Government did not request any information on it and
15 does not know how many healthcare workers lost their
16 lives from Covid-19 across Wales.

17 Sir Chris Whitty told the Inquiry that information
18 on deaths of healthcare workers is vital information for
19 tracking the impact of a pandemic. In retrospect, do
20 you think Welsh Government should have been gathering
21 the data to monitor the number of deaths of healthcare
22 workers during the pandemic?

23 **A.** Yeah, I think we should have, yes.

24 **Q.** Finally then, lessons learned and recommendations for
25 a future pandemic. The Inquiry has heard from the

178

1 places and, you know, I think the Inquiry is probably
2 the best place to do that because we've done all of the
3 individual reports. Now we've got to get a better sense
4 of actually they did that better in a different part of
5 the United Kingdom, what can we learn from that? And
6 I'm hoping that's what we'll get from here.

7 **Q.** What do you think -- given that you said the Welsh
8 Government or NHS Wales has undertaken a number of
9 lessons learned review, what are the key lessons that
10 emerge from that, in your view? What is it -- is there
11 anything that you think should be done differently next
12 time?

13 **A.** I think there's lots that could be done differently.
14 The -- you need to prepare for a pandemic and you need
15 to prepare by making sure that you reduce inequalities
16 before you go in. It's clear that the people who
17 suffered most, proportionately, were people who were
18 disadvantaged and who were vulnerable before we went in.
19 So getting rid of inequalities is -- before you get
20 in -- you're never going to get rid of them entirely but
21 reducing them would make sense. And we've got
22 a strategic plan that is very focused on that. And none
23 of that is straightforward because there's all kinds of
24 things affect that. You know, education standards and
25 what food you eat and all kinds of things. So,

180

1 you know, going into it fit makes sense.
 2 You know, the state of the NHS estate is poor, so
 3 additional capital investment would be helpful.
 4 I think for us in Wales in particular, trying to
 5 get more separation been planned care and emergency
 6 care. It's challenging, it's difficult in the kind of
 7 population base that we have, but where we have since
 8 introduced that, not just in West Wales but in that
 9 place where I found all those people not performing
 10 surgery, there's now a brand new hub that is being
 11 developed so that we can keep things separate, and then
 12 we can advance the planned care and not see that slow up
 13 in the way we did.
 14 Our ability to change is always going to be
 15 restricted by finance though and that's the real
 16 challenge for us. And I think what was -- there were
 17 some positives. I think the digital transformation that
 18 happened as a result, really quickly, remote
 19 consultations that's been -- that's really worked for
 20 lots of people in relation to GP access. But also in
 21 secondary care, particularly in rural areas. You know,
 22 if you're a long way from a dermatologist or a -- and,
 23 you know, you can do it all online, you know, that's
 24 a lot more convenient for some people.
 25 So I think the other thing is just to -- I think
 181

1 the pandemic, have been allowed to be with their baby on
 2 the neonatal ward.
 3 Were you aware that Wales was the last of the four
 4 nations to direct hospitals to allow both parents to
 5 have unrestricted access to their babies on the neonatal
 6 ward, ie to treat them as one unit, as Mr Gething
 7 I think put it this morning?
 8 **A.** I think Jean White is right, I think we should have
 9 introduced that earlier, and I think it's a magical time
 10 for parents and you need to allow them to be parents as
 11 soon as they can, irrespective of the circumstances. So
 12 although we may have been doing it for what we thought
 13 were the right reasons, there's a price that they've
 14 paid that they'll never get back.
 15 **Q.** Thank you.
 16 It's right, isn't it, at paragraph 258 of your
 17 statement, that the neonatal charity Bliss had been
 18 flagging this issue, making these very points to Welsh
 19 Government representatives in summer and autumn 2021.
 20 They were advocating for immediate changes to the Welsh
 21 guidance. Do you recall that?
 22 **A.** I do.
 23 **Q.** And it's also right, isn't it -- this is at
 24 paragraph 263 of your statement -- that it wasn't
 25 until May 2022, so almost a year later, that Welsh
 183

1 the NHS did remarkable work, and I think the staff on
 2 the front line did remarkable work and there's a lesson
 3 there as well to empower the frontline workers I think,
 4 give them responsibility. We gave them responsibility
 5 and we empowered them with a lot of money. It's very
 6 difficult to do that in times of peace but what they did
 7 was just incredible under the circumstances, and they
 8 acted really, really quickly. And, you know, if we
 9 could bring some of that magic back now it would be
 10 wonderful.

11 **MS NIELD:** Thank you very much.

12 I have no further questions for you,
 13 Baroness Morgan.

14 **LADY HALLETT:** Ms Waddoup, I think you're first up.
 15 Over that way.

Questions from MS WADDOUP

17 **MS WADDOUP:** Good afternoon, Baroness Morgan. I represent
 18 the 13 Pregnancy, Baby and Parent Organisations. You
 19 have given some very clear answers already about
 20 visiting restrictions in their maternity context, for
 21 which we're very grateful. I'd like to ask you, please,
 22 about your views on neonatal visiting restrictions.

23 The Inquiry has heard from Chief Nursing Officer
 24 Jean White that her view in hindsight was that both
 25 parents together should always, ie from the beginning of
 182

1 guidance (a) explicitly recognised the importance of
 2 parents being treated not as visitors but as partners in
 3 care, and then (b) moved away from the more
 4 discretionary trust-by-trust approach that had been in
 5 place previously towards a more mandatory approach,
 6 essentially requiring hospitals to allow parents, both
 7 parents, to attend to their babies at the same time?

8 **A.** Yeah, we took too long. You know, I took too long to
 9 make those changes. And if I had my time again, as
 10 I say, that is one of the things I definitely would have
 11 changed.

12 **Q.** Thank you. Can you help us with the reasons for that
 13 delay? Was it, for example, due to a lack of priority
 14 being accorded to women's and maternity-related care?

15 **A.** I don't think it was because of that in particular.
 16 I think it was probably just because we were under
 17 an inordinate amount of pressure. I was still very
 18 much, you know, a very new health minister, trying to
 19 find my way through a very, very complex system. You
 20 know, I was answering a hundred -- I was making
 21 a hundred decisions every Sunday, you know, on my day
 22 off. You know, the intensity of this is something
 23 I just can't begin to describe. So, you know, it wasn't
 24 deliberate.

25 **MS WADDOUP:** Thank you very much. Those are my questions.
 184

1 **LADY HALLETT:** Thank you very much.
2 Ms Jessica Jones. There you are, behind the
3 pillar.

4 **Questions from MS JONES**

5 **MS JONES:** Baroness Morgan, I ask questions on behalf of
6 John's Campaign, the Patients Association and Care
7 Rights UK, all of whom are organisations representing
8 people who draw on health and social care and their
9 loved ones.

10 My first question follows on from the theme that
11 Ms Waddoup was putting to you, the implementation of
12 visitor guidance, and you said in your evidence that the
13 national visiting guidance provided a baseline from
14 which there was flexibility for local decisions to be
15 made.

16 What, if anything, did you or your department do
17 to monitor how those restrictions were implemented to
18 ensure that local decisions to exclude or permit
19 visitors were proportionate and adequately took into
20 account the needs of individual patients?

21 **A.** Well, we were aware that there were differences
22 happening around the country that were in keeping with
23 the kind of waves of Covid and when they were happening,
24 so people were -- some of the health boards were letting
25 us know when they were tightening up those visiting

185

1 with them about patient experiences, of the
2 implementation of visitor guidance, for example, and the
3 other issues that patients were experiencing in the
4 delivery of healthcare during the pandemic?

5 **A.** So we have an organisation called Llais, which is the
6 formal representative body that speaks up on behalf of
7 patients in Wales, so obviously they were feeding in
8 regularly to policy developments, to proposals. So
9 there's a formal structure to make that happen.

10 **Q.** And did you feel, therefore, that patient views were
11 adequately represented in the decisions that you took?

12 **A.** I think the structure was definitely in place for that
13 to happen. So what I can't say is whether the
14 organisation actually truly reflected that when they
15 were taking everything else into account.

16 **MS JONES:** Thank you very much. Those are all my questions.

17 **LADY HALLETT:** Thank you, Miss Jones.

18 Mr Weatherby -- he is just there.

19 **Questions from MR WEATHERBY KC**

20 **MR WEATHERBY:** Thank you.

21 Good afternoon, First Minister. I ask questions
22 on behalf of the Covid-19 Bereaved Families for Justice
23 UK group, an organisation which includes many bereaved
24 families from Wales.

25 Just one topic, but an important one for those

187

1 restrictions, so there was definitely monitoring going
2 on in relation to that.

3 **Q.** But even in times when there were local outbreaks
4 necessitating greater restrictions, were you aware of
5 how decisions were being made about specific patients
6 who may, despite the particular local circumstances,
7 have had personal needs that required a care supporter
8 or visitor to continue to be provided access to them,
9 and how was that kept track of?

10 **A.** There's no way as a minister, with the kind of pressures
11 we were under, that I could have kept track on specific
12 patients. I think that would have been getting very
13 much into the operational weeds. And, you know, I think
14 you've heard earlier that my role was very much
15 a strategic one and the guidance was set out. The
16 operational matters is always one for the NHS itself.

17 **Q.** Thank you. My next question is about consultation with
18 patients, and here I don't mean individual patients, but
19 representative organisations like those for whom I act
20 today and others in this room and elsewhere.

21 You've said that you would, in retrospect, have
22 liked to have had more views feed into the decisions you
23 made and there was difficulty in getting frontline
24 views. But did you take any steps to try to obtain the
25 views of patients and family organisations to consult

186

1 that I represent, and it's support for bereaved
2 families.

3 The NHS Wales national nosocomial Covid-19
4 programme identified in its March 2023 interim learning
5 report -- I'll just give the reference for the record --
6 INQ000413883 at page 6.

7 It identified that bereavement services were
8 extremely important to those who had lost loved ones.
9 It identified that the provision of those services was
10 inconsistent across Wales and therefore identified as
11 a key learning area that bereavement support services
12 should be proactively made available in Wales to all
13 families who have lost loved ones and, in particular,
14 where there's an associated patient safety incident,
15 which would include Covid bereaved.

16 Can you help us, what action was taken consequent
17 to this report to ensure that the NHS in Wales was
18 properly providing those bereavement services and
19 consistently so?

20 **A.** Thanks. Well, as I mentioned earlier, we did look into
21 18,600 or so cases in terms of who had -- people who'd
22 got nosocomial infections and we -- that report, the
23 national -- included a national framework for delivery
24 of bereavement care and that was launched in 2021.

25 **Q.** Yeah.

188

1 **A.** And that produced then the National Bereavement Care
 2 Pathway. So that set out what should happen in the NHS
 3 throughout Wales. So that was the practical action as
 4 a result of the national framework.

5 **Q.** Well, the national framework that you reference was
 6 2021, and is talked about in the report I've just
 7 referred to, but my question was that you had the
 8 framework, this report identified in 2023 that
 9 effectively it was being applied inconsistently across
 10 Wales. So my question was, following this report, what
 11 was done to put that right?

12 **A.** I'm not clear -- I'm not sure what was done to put that
 13 right so I'll come back to you on that.

14 **Q.** Thank you very much. That's helpful.
 15 The second question, probably the same answer, is
 16 that the second learning point was about proactively
 17 signposting bereavement services at the earliest
 18 opportunity and my question, again, was the same. What
 19 was done about that? I assume your answer is the same,
 20 so it would be helpful if you could possibly come back
 21 to the Inquiry on that.

22 And, finally, about what assurance processes have
 23 been put in place on those two issues?

24 **A.** I'm just trying to -- so I've got the report in front of
 25 me which actually sets out exactly what the key learning

189

1 a space and therefore indicate the relative risk of
 2 something like Covid-19 spreading in the environment?

3 **A.** I remember this being an issue that was raised by the
 4 RCN during the pandemic, they were concerned about this,
 5 and one of the things we did was to -- so we did
 6 recognise that CO2 monitors had a role, but there were
 7 other things in relation to ventilation that needed to
 8 be considered and that's why what we had was an NHS
 9 specialist estates service that looked more broadly at
 10 ventilation not just at CO2 monitors.

11 **Q.** Thank you. And I'll get there in the end but can you
 12 just answer the question whether CO2 monitors in
 13 themselves assess how well ventilation is working in
 14 a room and therefore can be useful in assessing the risk
 15 that Covid-19 is spreading in the room?

16 **A.** I think there is recognition that there's a role for
 17 them but I think they're not the only mechanism of
 18 making sure that conditions are what they should be in
 19 hospitals.

20 **Q.** So it seems that you're accepting that they are
 21 a mechanism for assessing Covid-19?

22 **A.** They are a mechanism.

23 **Q.** Do you therefore accept, given that they're a mechanism
 24 which can assess the risk of Covid-19, that they're also
 25 one of the few measures, not the only measure but one of

191

1 is, what the good practice is, and what should be done
 2 as a result, and all of that is set out in the end of
 3 programme learning report on national nosocomial.

4 This came out just after I'd stopped being health
 5 minister --

6 **Q.** Yes.

7 **A.** -- so I can't tell you what's happened because
 8 I'd stopped being health minister when this report came
 9 out.

10 **Q.** I won't take it any further but the reason I put the
 11 interim report to you is because that was 2023.

12 **A.** Sure.

13 **MR WEATHERBY:** I won't take it any further. Thank you.

14 **LADY HALLETT:** Thank you, Mr Weatherby.
 15 Mr Wagner.
 16 Mr Wagner is over there.

17 **Questions from MR WAGNER**

18 **MR WAGNER:** Good afternoon, Baroness Morgan.
 19 My name is Adam Wagner and I ask questions on
 20 behalf of the Clinically Vulnerable Families. I want to
 21 ask you first, Baroness Morgan, about CO2 monitors.
 22 There's probably one around where you are sitting,
 23 they're sort of dotted around the Inquiry room.
 24 Do you accept that CO2 monitors, just in broad
 25 terms, assess how well ventilation is working within

190

1 the few measures which could be implemented which would
 2 allow clinically vulnerable people to monitor their
 3 relative safety when entering a healthcare space?

4 **A.** Well, I think it's got to be set against all of the
 5 other things that might be happening. So, you know, as
 6 I say, that Specialist Estates Services, you know, they
 7 were doing auditing, they were designing and making sure
 8 that there were alternatives, it didn't have to be all
 9 about CO2 monitoring, although they played a role also
 10 in giving advice on CO2 monitoring.

11 **Q.** Sorry, just go back to the question I was asking. Do
 12 you accept that they are a mechanism whereby clinically
 13 vulnerable people can monitor their relative safety when
 14 entering healthcare spaces?

15 **A.** Yes.

16 **Q.** Do you accept that CO2 monitors are relatively
 17 inexpensive to implement compared to redesigns of NHS
 18 estates or, you know, retrofitting of ventilation?

19 **A.** As I say, I think they're a mechanism. I think it's got
 20 to be set against all of the other things that are
 21 happening within that context but, yes, they are,
 22 relatively speaking, probably cheaper than some of the
 23 alternatives.

24 **Q.** Do you also accept that CO2 monitors would assist
 25 healthcare staff in knowing which spaces require further

192

1 ventilation or other measures such as opening windows,
 2 increasing air filtration and the like?
 3 **A.** I'm not an expert on these things, I'm not an expert on
 4 what system works better than the others, that's why
 5 we've got these Specialist Estates Services to advise us
 6 on those things and what works best.
 7 **Q.** So on that, at paragraph 252 of your witness statement,
 8 you refer to a March 2022 letter sent by the Royal
 9 College of Nursing requesting that you take steps to
 10 invest in the NHS estate, provide CO2 monitors and
 11 infection prevention and control nurse consultants.
 12 Your response indicated that there were no plans to
 13 provide CO2 monitors due to differing air change
 14 conditions required on individual settings and you gave
 15 similar answers in response to written questions in the
 16 Senedd on 11 March 2022. And I just want to ask you
 17 about those responses. Do you recall this?
 18 **A.** Yes, vaguely.
 19 **Q.** Yes. Given that you accept the CO2 monitors can be
 20 a useful tool, that they have benefits to clinically
 21 vulnerable people, and they're relatively inexpensive,
 22 why wasn't a precautionary policy of providing those
 23 monitors adopted?
 24 **A.** Well, there were huge pressures on us, we had to make
 25 difficult decisions in terms of precautionary
 193

1 a relatively cheap method of encouraging cleaner air,
 2 and therefore lessened risk of Covid-19 circulating
 3 within hospital settings it should be properly
 4 investigated?
 5 **A.** Yes, and I think that's what they were doing on that
 6 UK-wide group. I do know about air filtration systems
 7 because I was given one for Christmas. It was the most
 8 disappointing Christmas present I've ever had.
 9 **Q.** Do you use it?
 10 **A.** Not very often. But, you know, the reason it was bought
 11 is because I think -- my children, who were students at
 12 the time, were just about to come home and we -- and
 13 so -- and it was just -- I think it was a little bit of
 14 a "Right, let's see what we can do". But, you know,
 15 I've no idea how much it cost. As I said, it was
 16 a present and I have no idea whether it made any
 17 difference.
 18 **Q.** Finally, I want to ask you about antivirals.
 19 In March 2022 the shielding programme came to
 20 an official end, and one of the matters that you relied
 21 on in making that decision was the availability of
 22 medical treatment for those at high risk from Covid-19.
 23 This is in your statement at paragraph 277. Is that
 24 a fair representation of one of the factors that was
 25 involved?
 195

1 approaches. We were generally taking a precautionary
 2 approach in Wales. This is -- was not an issue that we
 3 didn't consider. But the key thing to remember is that
 4 the Specialist Estates Services that I've mentioned were
 5 actually on a UK group that was looking at ventilation
 6 in healthcare settings and they were looking at the
 7 monitoring of use of CO2 monitoring in healthcare, so
 8 they were doing that via a UK approach.
 9 **Q.** Looking back, do you think that was a bit of a missed
 10 opportunity?
 11 **A.** You can't win, can you? Sometimes you say, "Why were
 12 you doing it differently?" And now you're saying,
 13 you know, "You should have done it differently". So,
 14 you know, we thought we were doing what we needed to do
 15 through getting the expert advice of NHS Wales
 16 Specialist Estates Services and we were following their
 17 advice. They're the experts.
 18 **Q.** Portable air filtration systems. I think there is one
 19 next to in the Inquiry room, they're dotted around,
 20 sometimes referred to as HEPA filters. Professor Beggs,
 21 who is one of the Inquiry experts, has given evidence
 22 that those kind of systems have the potential to
 23 supplement existing ventilation systems, so sort of
 24 hardwired ventilation systems.
 25 Do you agree that if there is a potential for
 194

1 **A.** It was definitely a tool in our armoury, yeah.
 2 **Q.** Yes. In a letter sent out by the department on
 3 6 April 2022, responding to concerns about ending the
 4 programme, you set out information about the
 5 availability of medical treatments and antivirals
 6 available to assist in combating Covid-19 and which
 7 could assist more vulnerable groups. A number of CVF
 8 members, that's the group that I represent, report
 9 historic and ongoing difficulties in accessing
 10 antivirals within the required 5 to 7 days of infection,
 11 including difficulties of securing a referral, being
 12 positively triaged in time. Can you recall what, if
 13 any, processes you had in place to ensure prompt access
 14 to antivirals for those who were at the highest risk in
 15 Wales?
 16 **A.** Yes. I remember us having quite a sophisticated
 17 operation, so we had a very comprehensive database of
 18 who were on that clinically vulnerable risk group, and
 19 if they had Covid it would trigger an alert, which means
 20 that they would get the antivirals sent to them
 21 directly. So I thought it was quite a sophisticated
 22 operation.
 23 **Q.** Do you accept that if antivirals were, in fact, not
 24 practicably available for or offered to many people at
 25 higher risk from Covid-19 who became infected, they
 196

1 couldn't reasonably be considered as a justification for
2 ending shielding?
3 **A.** Yes, which is why we had a very organised system to make
4 sure that it -- that there was a very speedy response.

5 **MR WAGNER:** Thank you, those are my questions.

6 **LADY HALLETT:** Thank you, Mr Wagner.

7 Ms Hannett, who's at the back there.

8 **Questions from MS HANNETT KC**

9 **MS HANNETT:** Baroness Morgan, I ask questions on behalf of
10 the Long Covid groups.

11 My Lady, we're very grateful to Counsel to the
12 Inquiry who has in fact asked and raised all the
13 questions that we were given permission to do. May I,
14 instead, ask permission to raise one short question with
15 Baroness Morgan regarding the evidence that she's just
16 given this afternoon?

17 **LADY HALLETT:** Certainly.

18 **MS HANNETT:** Thank you, my Lady.

19 Baroness Morgan, you gave evidence just now that
20 just 3.5% of Long Covid patients were referred to
21 secondary care. Isn't this extremely low figure a red
22 flag that Long Covid patients are not receiving access
23 to specialist clinical care?

24 **A.** I'm not an expert. That's why we had an assessment of
25 the Adferiad programme and they didn't flag up that they
197

1 undertaken by Professor Fong in England took place in
2 Wales.

3 The Welsh Government did not commission
4 a look-back exercise or review to investigate into the
5 issue of inappropriate DNACPR exercises as happened in
6 England.

7 And Welsh Government did not undertake
8 an assessment of the effectiveness of its shielding
9 programme as Public Health Scotland and DHSC did.

10 Do you agree in light of those examples, there has
11 been a failure by the Welsh Government to open itself up
12 to scrutiny in relation to the performance of the
13 healthcare system in Wales during the pandemic?

14 **A.** I think there's lots of things that we can learn as
15 a result of the pandemic. This was an unprecedented
16 situation and we were all responding to the best of our
17 abilities with the information that we had in front of
18 us at the time.

19 Are there lessons we can learn? Absolutely. I'm
20 really hoping that this Inquiry will help us to learn
21 some of those lessons.

22 No, we didn't do a national cluster exercise but
23 we did investigate every single individual that had
24 a nosocomial infection in our hospital, and I'm not sure
25 if that happened across the United Kingdom.
199

1 thought this was an issue.

2 **Q.** Do you agree that it maybe perhaps highlights
3 a misconception in Wales that Long Covid is primarily
4 about management of rehabilitation rather than a complex
5 multi-organ disease which requires clinical management?

6 **A.** I rely on experts when it comes to how to clinically
7 manage particular conditions and that's particularly
8 true in relation to what is a relatively new and still
9 not entirely understood condition.

10 **MS HANNETT:** My Lady, I'm grateful.

11 **LADY HALLETT:** Thank you, Ms Hannett.

12 Ms Shepherd, who is behind the pillar.

13 **Questions from MS SHEPHERD**

14 **MS SHEPHERD:** Prynawn da, Brif Weinidog.

15 I ask questions on behalf of Covid-19 Bereaved
16 Families for Justice Cymru. We have found a number of
17 examples in this module where it appears that the Welsh
18 Government did not subject itself to the same level of
19 scrutiny about what went wrong during the pandemic as
20 other nations of the UK. I've got four examples for
21 you.

22 Firstly, no national investigations into cluster
23 outbreaks in hospitals were undertaken in Wales as they
24 were in Northern Ireland.

25 No pilot pulse survey akin to that which was
198

1 I'm not sure what your -- I think your second
2 point was something about pulse. I don't know --
3 sorry, if you could repeat that.

4 **Q.** That was the study where Professor Fong went into
5 hospitals in England to look at what was happening on
6 the ground as opposed to just receiving the data.

7 **A.** Ah, okay. Well, look, you've heard that, you know,
8 I tried to do what I could as a minister within the
9 parameters I could in the middle of a pandemic to get
10 a better sense of what was happening on the ground.

11 When it comes to DNACPR, then we've had this
12 follow-up to try and make sure that we initiate and we
13 look at what more needs to be done in that space. And
14 on shielding, you know, I'll be very happy to see what
15 the Inquiry comes up with. The shielding in England
16 stopped much earlier than ours did so, you know, it will
17 be interesting to see what comes out of that.

18 But, again, we had to balance not just shielding
19 but also, as I mentioned earlier, the other issues that
20 arise as a result of shielding, including social
21 isolation and mental health issues.

22 **Q.** I'm going to go on to my second topic which is data
23 collection. Major outbreaks in hospitals were recorded
24 via, I think it's either the ICNet or the IC Net
25 database. To what extent did you rely on the data from
200

1 that database for policy making?
 2 **A.** It's fed into the general policy-making approach.
 3 **Q.** We've learned from the statement of
 4 Professor Fu-Meng Khaw from Public Health Wales that
 5 a surveillance quality assurance group was set up to
 6 feed back to the Welsh Government and health boards on
 7 any issues of data quality and completeness and for
 8 health board medical directors to feed back in turn.
 9 What was your understanding of how that database was
 10 used by the surveillance quality assurance group to
 11 monitor and respond to outbreaks in hospitals?
 12 **A.** I haven't got the detail on that information.
 13 **Q.** Are you aware of any deficiencies in the ICNET database?
 14 **A.** I'm not aware of any issues, no.
 15 **Q.** I'm going to ask, then, that INQ000327640 is brought up
 16 on the screen. I think it's at tab 52 within your
 17 bundle.
 18 For reference, these are questions that are posed
 19 by members of CBFJ Cymru, in the one column, and the
 20 "Welsh Government Response" column is from your time in
 21 office, so it was either by yourself or someone from
 22 your office.
 23 If we could look at page 3 of this document, in
 24 the second box down, what's said in answer to
 25 question 12 is:

201

1 Wales?
 2 **A.** Well, we had a specific group whose job was to give
 3 advice on nosocomial infections, so that data piece
 4 would have been a part of that group.
 5 **Q.** I'm going to move on then to the final topic, which is
 6 clean air. In March 2022 the Royal College of Nursing
 7 sent out a briefing that the spread of Covid-19 was
 8 higher in areas with poor ventilation. This in turn led
 9 to questions being asked of you about ventilation in the
 10 Senedd. Given that this had been a problem of which
 11 Welsh Government had been aware since the first wave,
 12 how was it that poor ventilation was still a problem in
 13 advance of the third wave in the winter of 2021, 2022?
 14 **A.** Well, we have older hospitals. You know, we've had
 15 years of capital restriction so we haven't been able to
 16 do the kind of -- we weren't able to do the kind of
 17 individual isolation that can be done in more modern
 18 hospitals.
 19 **Q.** The next topic then is HEPA filters. You spoke earlier
 20 about some of the things the Welsh Government can do to
 21 direct the health boards. Did you give any
 22 consideration to providing guidance or issuing
 23 a direction as to the use of HEPA filters in Welsh
 24 hospitals at a national level?
 25 **A.** I can't remember giving any specific advice on that, no.

203

1 "Problems were identified with the outbreak module
 2 of the ICNeT which have ... been addressed."
 3 Are you aware of what the cause of those problems
 4 were?
 5 **A.** I can't recall what the cause were, no.
 6 **Q.** In which case I'll move on from this point. A concern
 7 of those who I represent is the number of cluster
 8 outbreaks in Welsh hospitals. And was that a difficulty
 9 as a result of the data collection in Wales?
 10 **A.** I'm not sure if as a result of data collection. We were
 11 testing a lot of people, we were looking for it all of
 12 the time. So, you know, we know our rates were very
 13 high but we were actually looking for it, deliberately
 14 going out and making sure that we tested everybody. So
 15 that might have explained why our rates were higher.
 16 **Q.** Do you agree there were gaps or deficiencies in the data
 17 recording?
 18 **A.** In the middle of a pandemic it wouldn't surprise me
 19 at all if that were the case. People were being
 20 stretched left, right and centre, people on the front
 21 line who were under incredible pressure, and I'm sure
 22 there were times when data wasn't recorded at all times
 23 accurately.
 24 **Q.** Did you take any steps to ensure that data on nosocomial
 25 infections could be properly collected and analysed in

202

1 **MS SHEPHERD:** Diolch yn fawr.
 2 Those are my questions, thank you, my Lady.
 3 **LADY HALLETT:** Thank you very much, Ms Shepherd.
 4 Thank you very much, Baroness Morgan, those are
 5 all the questions that we have for you. May I say this,
 6 that you are one of those rare beings which is a witness
 7 who answers the questions in a focused manner and
 8 a relatively short manner and at a measured pace. I can
 9 tell you that not all of us can claim such a thing.
 10 Anyway, thank you very much for your help.

11 **A.** Diolch yn fawr. Thank you.

12 (The witness withdrew)

13 **LADY HALLETT:** Very well, 10 o'clock tomorrow.

14 (4.22 pm)

15 (The hearing adjourned until 10.00 am on

16 Thursday, 21 November 2024)

17

18

19

20

21

22

23

24

25

204

	INDEX	
		PAGE
1		
2		
3	MR VAUGHAN GETHING (affirmed)	1
4	Questions from LEAD COUNSEL	1
5	TO THE INQUIRY for MODULE 3	
6	Questions from	85
7	MR WEATHERBY KC	
8	Questions from MR WAGNER	92
9	Questions from MS WADDOUP	96
10	Questions from	99
11	PROFESSOR THOMAS KC	
12	Questions from MS HANNETT KC	105
13	Questions from MS SHEPHERD	108
14	BARONESS ELUNED MORGAN (sworn)	122
15	Questions from COUNSEL TO THE	122
16	INQUIRY	
17	Questions from MS WADDOUP	182
18	Questions from MS JONES	185
19	Questions from MR	187
20	WEATHERBY KC	
21	Questions from MR WAGNER	190
22	Questions from MS HANNETT KC	197
23	Questions from MS SHEPHERD	198
24		
25		

LADY HALLETT: [36] 1/3 1/7 1/10 6/23 7/1 7/5 7/12 57/17 57/22 85/23 92/8 96/17 98/23 104/23 105/4 108/9 121/13 121/23 122/2 122/6 150/18 150/21 150/24 151/2 167/9 167/13 169/3 182/14 185/1 187/17 190/14 197/6 197/17 198/11 204/3 204/13 MR WAGNER: [4] 92/11 96/16 190/18 197/5 MR WEATHERBY: [4] 85/25 92/6 187/20 190/13 MS CAREY: [11] 1/4 1/13 6/22 6/24 7/3 7/9 7/15 57/15 57/18 57/23 85/20 MS HANNETT: [6] 105/1 105/6 108/7 197/9 197/18 198/10 MS JONES: [2] 185/5 187/16 MS NIELD: [7] 122/3 122/11 151/7 167/7 167/14 169/4 182/11 MS SHEPHERD: [4] 108/12 121/11 198/14 204/1 MS WADDOUN: [4] 96/20 98/21 182/17 184/25 PROFESSOR THOMAS: [2] 99/1 104/21 THE WITNESS: [5] 1/12 7/11 7/14 12/21 122/9 UNIDENTIFIED SPEAKER: [1] 6/21 ' incidents [1] 135/24 ' normal' [1] 128/3 ' second [1] 135/18 1 1 April [3] 58/5 58/22 59/7 1 February 2022 [1] 162/15 1 March [1] 39/6 1 March 2020 [1] 135/12 1 million [1] 175/23 1,000 [2] 52/11 59/7 1,500 [1] 59/7	1.55 [1] 121/23 1.55 pm [1] 122/1 10 [2] 52/11 172/24 10 o'clock [1] 204/13 10.00 [2] 1/2 204/15 100 [11] 10/18 19/22 21/15 21/16 21/19 23/22 160/9 171/13 172/25 173/13 175/3 100 military [1] 171/19 108 [1] 16/7 109 [1] 16/7 11 March 2022 [1] 193/16 11.14 [1] 57/19 11.30 [2] 57/17 57/21 110 [1] 172/10 110 drivers [1] 171/25 12 [1] 201/25 12 weeks [1] 51/18 12.58 pm [1] 121/24 13 [1] 182/18 13 March [4] 3/6 16/6 16/13 21/4 13 May 2021 [1] 1/24 13 Pregnancy [1] 96/21 13 surgeons [1] 149/11 13.5 [1] 175/1 130 [1] 50/25 1360 [1] 135/20 138 [1] 86/11 145 [2] 19/1 21/12 15 [2] 133/12 170/17 15 December [1] 172/18 15 June [1] 72/6 15 October [1] 170/13 15 weeks [1] 39/1 15-week [1] 39/10 150 [1] 170/5 16 [1] 127/23 16 August [2] 72/15 92/18 16 August 2020 [1] 72/8 16 June 2021 [1] 127/20 16 November [2] 112/19 112/20 16 November 2020 [1] 112/18 160 [1] 99/6 163 [1] 101/5 164 [3] 76/19 76/19 101/5 17 November 2021 [1] 172/13 172 [1] 146/9 172 beds [1] 146/6	18 [1] 146/8 18,600 [1] 188/21 18,630-odd [1] 137/14 19 [43] 45/19 49/12 51/5 51/9 64/7 74/15 74/21 74/25 75/5 86/4 102/16 108/13 114/22 123/4 129/18 129/19 129/22 129/23 131/19 135/13 135/21 135/24 137/3 140/1 140/6 144/17 155/21 170/10 176/12 178/13 178/16 187/22 188/3 191/2 191/15 191/21 191/24 195/2 195/22 196/6 196/25 198/15 203/7 19 May [1] 59/17 19 May 2020 [1] 60/13 19 November 2021 [1] 169/7 1:1 [2] 25/14 26/13 1:2 [2] 26/17 27/24 2 2 million [1] 145/4 2,000 [1] 59/7 20 April [1] 58/18 20 November 2024 [1] 1/1 200 [1] 23/23 2011 [1] 1/19 2014 [1] 117/9 2016 [2] 1/19 7/22 2018 [1] 122/23 2020 [34] 2/3 2/24 9/6 24/16 38/24 49/1 51/4 52/25 53/5 58/4 59/17 60/11 60/13 63/14 63/17 67/16 68/13 72/5 72/8 74/21 78/7 79/4 86/10 92/20 112/16 112/18 114/24 116/11 117/8 122/19 122/24 129/11 135/12 168/5 2021 [47] 1/24 38/24 52/16 55/3 67/14 68/13 69/21 83/20 105/14 106/15 113/16 113/19 115/12 122/15 122/19 123/3 127/20 129/15 135/4 135/12 135/18 138/14 144/14 146/23 151/9 151/20 153/8 153/20 155/18 155/23 156/10 156/15 157/11 167/18 167/23 169/6 169/7 169/10 169/18 169/19 169/23 172/13 176/11 183/19 188/24 189/6 203/13	2021-2022 [1] 145/9 2022 [20] 138/12 143/7 145/9 146/21 148/12 157/7 159/18 162/15 164/7 167/19 169/19 170/13 172/19 183/25 193/8 193/16 195/19 196/3 203/6 203/13 2023 [5] 137/5 163/23 188/4 189/8 190/11 2024 [5] 1/1 122/15 137/6 171/11 204/16 21 [1] 38/21 21 April [2] 88/10 88/24 21 March [1] 58/4 21 November 2024 [1] 204/16 210 cases [1] 63/20 22 [1] 29/14 22 November 2021 [1] 169/10 23 June 2021 [1] 135/18 23 November [1] 135/18 232 [1] 135/19 24 [1] 64/17 24 March [3] 41/14 88/6 90/23 24 March 2020 [1] 116/11 24 September 2024 [1] 171/11 24th [1] 44/9 250 [1] 172/9 251 [3] 170/11 172/19 172/20 251 drivers [2] 171/12 172/14 252 [1] 193/7 258 [1] 183/16 263 [1] 183/24 277 [1] 195/23 292 [1] 162/17 295 [1] 58/3 296 [1] 58/16 2B [1] 13/16 3 3 million [1] 145/5 3.10 pm [1] 167/10 3.25 [2] 97/1 167/9 3.25 pm [1] 167/12 3.5 [3] 64/6 159/15 197/20 30 [2] 159/22 160/4 30 June 2021 [1] 135/4 30 May 2021 [1] 135/12 303 [1] 113/1	304 [1] 112/14 31 July [4] 72/7 72/10 86/13 86/22 31 March [1] 61/5 31 March 2022 [1] 170/13 317 [1] 88/9 32 [1] 16/9 3387 [1] 135/20 34 [1] 79/4 345 [2] 50/23 51/4 4 4 December [1] 112/21 4 December 2020 [1] 112/16 4 o'clock [1] 16/12 4.22 pm [1] 204/14 40 [1] 153/13 42 [1] 170/14 45 [1] 115/1 5 5 million [5] 155/19 156/2 169/8 169/16 173/11 5,000 [2] 58/23 59/4 50 [2] 10/18 63/21 52 [1] 201/16 56,000 [1] 52/17 58 [2] 13/11 13/14 6 6 April 2022 [1] 196/3 6,000 [1] 58/5 60 [3] 10/18 11/9 176/20 69 [1] 176/10 69 million [1] 136/12 7 7 April [3] 58/6 58/22 59/8 7 days [1] 196/10 7 Level [1] 128/1 7,127 [1] 135/12 7.7 million [1] 136/12 70 [1] 160/4 700,000 [1] 158/1 71 [1] 176/18 72 [1] 130/4 74 [1] 79/6 750 [1] 21/14 770 [1] 173/24 78 [1] 110/21 8 8 November [1] 63/19 8,000 [2] 58/5 129/23 83 [1] 160/3 86 [1] 24/16
---	--	--	--	--

8	84/13 107/17 109/2 113/12 154/10 181/20 183/5 186/8 196/13 197/22	28/7 29/9 34/14 34/16 35/22 36/12 36/23 37/3 39/16 40/7 40/13 41/1 42/6 44/12 46/2 46/14 47/10 48/20 49/23 50/16 53/13 59/25 61/22 62/1 62/18 62/22 65/16 68/7 71/7 72/9 73/3 74/1 74/4 75/13 78/8 79/14 79/17 82/22 83/6 83/11 84/9 85/9 87/9 87/20 88/23 89/1 89/23 90/12 90/23 93/11 95/6 104/2 104/14 107/8 112/1 115/15 115/21 116/1 116/2 129/3 131/20 133/13 138/5 139/22 140/20 142/22 146/11 146/13 150/6 152/11 161/6 161/8 180/4 187/14 189/25 194/5 202/13	94/20 95/4 97/14 administrations [1] 86/24 admit [1] 29/22 admitted [3] 31/3 31/4 41/18 adopted [3] 102/2 158/18 193/23 adopting [2] 136/15 158/22 adult [1] 19/3 advance [2] 181/12 203/13 advanced [2] 166/9 166/12 advantage [1] 41/9 advantaged [1] 25/3 advantages [1] 166/20 advice [38] 11/22 51/15 51/16 52/14 53/11 94/12 94/21 95/1 96/7 96/9 105/15 105/19 105/20 106/5 106/11 106/16 108/4 126/11 127/8 142/13 151/14 151/17 153/16 153/22 154/17 155/18 169/7 169/25 171/11 171/16 171/24 172/2 172/5 192/10 194/15 194/17 203/3 203/25 advices [1] 70/19 advisable [1] 152/4 advise [1] 193/5 advised [3] 151/23 156/11 171/12 adviser [9] 3/24 48/22 54/19 55/6 60/2 60/3 110/11 110/12 113/2 advisers [1] 107/4 advising [4] 96/6 151/25 152/23 153/1 advisory [4] 74/15 80/19 126/21 176/13 advocate [2] 97/7 97/16 advocating [1] 183/20 affect [2] 153/24 180/24 affected [11] 13/17 55/22 56/14 77/15 78/23 81/8 84/9 109/13 115/22 141/13 174/10 affects [5] 48/19 55/10 84/24 104/7 104/8 affirm [1] 1/6 affirmed [2] 1/8 205/3 afraid [2] 28/23 45/21	after [13] 9/24 11/24 12/2 32/9 51/18 94/9 97/9 97/23 106/16 143/9 157/1 167/23 190/4 after-birth [1] 97/9 aftereffects [1] 49/13 afternoon [10] 85/25 92/11 96/20 99/1 108/12 149/10 182/17 187/21 190/18 197/16 afterwards [3] 101/15 150/23 165/23 again [37] 1/11 6/11 12/5 12/10 17/5 17/7 20/22 25/11 33/4 37/11 39/10 46/21 47/11 65/10 67/5 68/25 70/20 72/24 73/8 80/3 88/4 111/2 118/24 136/21 137/1 142/9 143/16 149/9 150/13 153/15 154/1 154/17 158/12 164/7 184/9 189/18 200/18 against [6] 8/17 71/4 111/16 154/20 192/4 192/20 age [3] 99/9 104/17 117/21 ageing [3] 117/6 117/10 118/21 agree [23] 8/7 28/1 38/2 39/15 56/3 56/12 75/6 92/19 92/24 93/15 107/19 109/3 111/19 115/12 116/16 156/14 166/16 167/3 169/8 194/25 198/2 199/10 202/16 agreed [5] 49/1 118/9 169/9 169/17 172/17 agreeing [1] 66/19 agreement [2] 57/3 121/8 Ah [1] 200/7 ahead [2] 87/10 158/9 aid [7] 25/6 27/13 27/18 45/3 89/17 91/20 169/20 air [6] 193/2 193/13 194/18 195/1 195/6 203/6 airport [1] 90/9 akin [1] 198/25 Alan [3] 35/20 35/23 37/2 Alan Brace [3] 35/20 35/23 37/2 albeit [3] 29/2 131/8 161/1 alert [1] 196/19 alike [1] 79/2
87 [1] 159/14				
9	accessible [2] 53/15 102/18 accessing [1] 196/9 accompanied [1] 97/6 accordance [1] 58/9 accorded [1] 184/14 accordingly [1] 171/23 account [13] 2/11 6/18 29/17 33/1 55/12 93/25 102/8 103/10 126/3 137/19 150/16 185/20 187/15 accountability [3] 125/25 126/5 126/7 accurate [1] 110/4 accurately [1] 202/23 achieved [1] 168/4 acknowledgement [2] 29/3 48/11 acknowledges [1] 61/8 acquire [1] 70/24 acquired [7] 59/15 61/12 61/18 63/20 116/15 117/3 137/8 acquiring [1] 59/15 across [26] 18/18 27/12 39/25 42/24 64/8 68/5 76/13 76/21 79/6 91/13 97/2 107/3 111/19 120/5 128/2 141/10 155/16 157/12 166/14 166/21 170/15 178/16 179/8 188/10 189/9 199/25 act [2] 15/11 186/19 acted [5] 53/12 63/2 91/6 164/20 182/8 action [12] 16/14 66/19 76/12 76/16 99/19 165/22 168/22 170/18 171/4 178/7 188/16 189/3 actioned [2] 138/19 140/20 actions [3] 165/24 167/15 168/8 actively [1] 102/13 activity [10] 6/17 12/2 12/13 20/10 20/25 69/19 90/14 128/3 130/18 149/19 actually [96] 4/22 4/24 5/1 8/14 8/15 9/25 10/2 11/21 12/4 12/14 15/12 20/8 20/11 20/16 21/6 21/20 22/1 25/5 25/18	advice [38] 11/22 51/15 51/16 52/14 53/11 94/12 94/21 95/1 96/7 96/9 105/15 105/19 105/20 106/5 106/11 106/16 108/4 126/11 127/8 142/13 151/14 151/17 153/16 153/22 154/17 155/18 169/7 169/25 171/11 171/16 171/24 172/2 172/5 192/10 194/15 194/17 203/3 203/25 advices [1] 70/19 advisable [1] 152/4 advise [1] 193/5 advised [3] 151/23 156/11 171/12 adviser [9] 3/24 48/22 54/19 55/6 60/2 60/3 110/11 110/12 113/2 advisers [1] 107/4 advising [4] 96/6 151/25 152/23 153/1 advisory [4] 74/15 80/19 126/21 176/13 advocate [2] 97/7 97/16 advocating [1] 183/20 affect [2] 153/24 180/24 affected [11] 13/17 55/22 56/14 77/15 78/23 81/8 84/9 109/13 115/22 141/13 174/10 affects [5] 48/19 55/10 84/24 104/7 104/8 affirm [1] 1/6 affirmed [2] 1/8 205/3 afraid [2] 28/23 45/21		
A				
abandoned [4] 58/20 72/18 73/11 86/18 abilities [1] 199/17 ability [9] 7/23 8/8 12/4 12/8 56/9 82/4 83/1 118/22 181/14 able [33] 11/23 15/2 15/10 15/11 20/25 22/16 36/15 40/2 41/3 64/23 73/13 81/23 89/14 94/4 110/3 112/24 114/17 115/15 116/2 117/2 125/9 132/25 133/15 138/9 139/24 145/25 148/21 153/25 154/6 174/9 175/16 203/15 203/16 about [337] about: [1] 111/4 about: what [1] 111/4 above [2] 26/17 27/24 abrupt [2] 86/17 86/25 absence [4] 5/23 7/16 167/20 174/8 absent [2] 82/16 174/3 absolutely [5] 18/1 148/17 157/22 176/6 199/19 Academy [3] 3/25 6/8 6/10 accelerate [1] 5/6 accept [14] 13/7 45/17 63/1 106/10 113/20 150/21 172/2 190/24 191/23 192/12 192/16 192/24 193/19 196/23 acceptable [1] 176/21 accepted [2] 87/4 171/24 accepting [1] 191/20 access [15] 45/7 55/24 56/6 83/22 84/4				

<p>A</p> <p>all [113] 2/3 2/9 2/18 4/4 4/25 6/24 7/10 7/19 9/5 16/18 17/15 18/7 19/9 19/24 20/11 22/14 23/11 24/6 25/23 34/23 37/15 37/17 38/11 42/11 44/14 44/20 50/20 52/15 52/24 53/6 53/21 54/23 56/22 57/24 59/6 59/12 61/11 62/6 63/9 63/21 63/21 69/12 70/22 71/12 75/15 76/8 77/1 79/12 80/2 82/1 83/17 85/20 86/9 87/18 89/11 92/14 93/24 94/4 94/23 111/21 114/9 120/5 121/10 127/14 134/8 135/24 137/19 137/21 138/7 138/18 139/19 140/7 145/7 154/9 156/13 157/15 157/16 157/19 160/22 162/22 163/2 165/25 166/22 167/2 172/24 173/10 173/17 176/14 176/22 177/6 177/10 177/14 179/18 179/20 180/2 180/23 180/25 181/9 181/23 185/7 187/16 188/12 190/2 192/4 192/8 192/20 197/12 199/16 202/11 202/19 202/22 204/5 204/9</p> <p>all-Wales [1] 176/14</p> <p>allegations [1] 164/19</p> <p>alleged [1] 164/13</p> <p>allocated [1] 117/15</p> <p>allocates [1] 117/16</p> <p>allow [9] 15/25 17/4 86/7 97/14 141/6 183/4 183/10 184/6 192/2</p> <p>allowed [2] 97/12 183/1</p> <p>almost [7] 42/7 50/20 50/20 52/13 57/2 74/9 183/25</p> <p>alongside [2] 75/22 173/11</p> <p>already [14] 68/12 70/3 70/10 72/9 72/12 86/7 87/11 95/7 123/22 129/1 142/25 154/15 155/16 182/19</p> <p>also [71] 5/8 6/6 17/10 20/13 21/7 25/2 25/6 26/3 26/11 27/12 30/9 35/17 36/10</p>	<p>36/17 38/13 41/3 43/23 44/23 46/11 48/16 50/12 57/4 58/24 59/2 66/24 70/3 73/24 75/3 76/1 77/23 78/2 78/3 81/20 85/7 88/12 89/17 91/22 92/24 93/5 93/15 93/21 94/9 97/8 106/13 108/17 110/7 111/13 115/21 119/15 124/25 126/8 126/12 129/21 130/24 132/10 140/2 144/1 146/23 149/5 157/9 159/21 164/4 165/18 169/19 174/2 181/20 183/23 191/24 192/9 192/24 200/19</p> <p>alternatives [3] 171/2 192/8 192/23</p> <p>although [13] 8/2 26/25 39/16 64/15 83/20 86/12 113/15 130/12 141/8 150/11 178/11 183/12 192/9</p> <p>always [32] 8/16 10/7 13/25 35/1 42/8 45/6 45/23 48/5 54/7 54/10 56/13 56/15 59/2 62/9 69/14 75/9 79/19 82/8 103/17 109/24 110/18 111/11 121/3 126/14 133/6 143/13 159/6 162/8 162/24 181/14 182/25 186/16</p> <p>am [11] 1/2 57/19 57/21 67/22 72/1 105/2 108/14 136/23 160/20 164/10 204/15</p> <p>ambition [2] 58/4 58/7</p> <p>ambulance [39] 5/9 5/19 134/2 134/2 167/16 167/18 167/25 168/2 168/12 168/13 168/15 168/17 169/5 169/9 169/13 169/17 169/22 170/3 170/4 170/12 170/15 170/21 172/5 172/16 173/6 173/12 173/13 173/16 173/18 174/4 174/6 174/7 174/11 175/3 175/6 175/7 175/9 175/11 175/13</p> <p>ambulances [1] 170/13</p> <p>amendments [1] 143/6</p> <p>amongst [2] 43/24 76/8</p> <p>amount [11] 59/10 67/19 89/21 90/6</p>	<p>117/15 117/21 137/17 141/17 166/15 173/22 184/17</p> <p>amounts [1] 44/20</p> <p>analysed [1] 202/25</p> <p>Andrew [6] 124/21 127/21 127/22 129/12 171/12 171/25</p> <p>Andrew Goodall [5] 124/21 127/22 129/12 171/12 171/25</p> <p>anecdotal [4] 20/13 30/4 31/1 109/7</p> <p>anecdotes [1] 4/6</p> <p>Aneurin [4] 21/3 22/6 60/24 61/6</p> <p>Aneurin Bevan [1] 60/24</p> <p>announced [7] 72/10 87/6 88/2 112/15 112/20 145/9 163/23</p> <p>announcement [3] 18/10 89/25 112/17</p> <p>announcing [2] 17/18 17/21</p> <p>anonymised [1] 56/11</p> <p>another [5] 21/14 21/19 104/7 131/6 164/5</p> <p>answer [9] 28/10 35/12 52/22 71/7 112/22 189/15 189/19 191/12 201/24</p> <p>answer to [1] 71/7</p> <p>answering [1] 184/20</p> <p>answers [4] 160/7 182/19 193/15 204/7</p> <p>anti [1] 178/7</p> <p>anti-racism [1] 178/7</p> <p>anticipate [1] 73/6</p> <p>anticipated [4] 51/8 51/13 53/4 89/11</p> <p>anticipating [1] 21/5</p> <p>antivirals [6] 195/18 196/5 196/10 196/14 196/20 196/23</p> <p>anxiety [1] 41/2</p> <p>any [63] 7/5 9/20 15/20 17/2 23/20 24/21 33/11 36/21 55/13 58/12 64/20 67/18 69/7 70/14 71/15 77/15 78/11 80/6 80/12 84/2 89/23 94/15 97/18 99/10 109/9 109/19 113/6 130/24 131/4 131/15 132/10 132/12 140/3 141/11 142/13 145/19 147/1 148/15 152/25 154/8 157/11 158/22 161/14 162/9 162/20 163/3 163/10 163/16</p>	<p>164/25 175/5 175/16 178/14 186/24 190/10 190/13 195/16 196/13 201/7 201/13 201/14 202/24 203/21 203/25</p> <p>anybody [1] 94/15</p> <p>anything [9] 33/22 40/25 44/13 68/14 114/6 147/4 150/25 180/11 185/16</p> <p>anyway [3] 99/23 147/8 204/10</p> <p>apart [2] 58/23 130/6</p> <p>apparent [2] 21/1 88/23</p> <p>appear [4] 105/6 108/12 129/25 130/2</p> <p>appeared [2] 37/9 168/15</p> <p>appearing [1] 1/5</p> <p>appears [3] 45/18 130/21 198/17</p> <p>application [1] 162/14</p> <p>applied [2] 164/11 189/9</p> <p>appointed [2] 155/14 155/24</p> <p>appointment [3] 157/1 160/14 161/7</p> <p>appointments [5] 14/8 33/23 97/16 160/15 161/16</p> <p>appreciate [3] 30/14 54/3 82/5</p> <p>appreciated [1] 133/10</p> <p>approach [29] 8/6 8/6 8/14 20/9 49/11 51/10 52/4 53/22 53/23 70/11 71/21 91/5 95/20 95/22 103/20 104/10 125/15 128/20 141/10 142/9 148/1 153/5 156/11 156/16 184/4 184/5 194/2 194/8 201/2</p> <p>approached [1] 86/15</p> <p>approaches [3] 57/8 57/14 194/1</p> <p>appropriate [18] 13/21 15/10 34/24 34/25 35/5 53/13 80/15 80/25 106/3 106/6 107/2 107/7 107/20 107/22 112/1 153/21 161/20 165/1</p> <p>appropriately [1] 165/15</p> <p>approval [1] 117/24</p> <p>approve [2] 118/4 169/19</p> <p>approved [1] 118/12</p>	<p>approving [1] 124/18</p> <p>approximately [1] 64/18</p> <p>April [29] 2/24 18/24 34/21 35/6 38/24 52/16 58/5 58/6 58/6 58/18 58/18 58/22 58/22 58/22 59/7 59/8 59/8 88/10 88/24 89/13 89/24 90/19 90/20 90/25 90/25 129/11 138/14 164/6 196/3</p> <p>April 2021 [2] 38/24 52/16</p> <p>aprons [3] 39/17 39/23 40/17</p> <p>are [179] 1/17 2/1 2/9 2/15 2/20 4/12 4/14 5/18 5/21 7/9 9/1 9/3 9/14 10/1 10/12 10/13 11/7 11/12 12/8 13/4 15/15 17/6 17/19 22/7 23/2 23/6 23/11 23/15 25/18 27/7 27/16 27/24 28/8 28/16 28/17 28/25 30/10 30/15 31/17 33/24 36/25 37/2 37/12 38/20 40/15 42/5 43/3 47/4 50/9 50/19 51/2 51/17 53/24 54/8 57/1 57/1 62/24 63/17 64/6 65/19 66/10 66/16 66/17 66/18 66/23 69/9 69/10 72/3 73/1 74/7 75/3 76/22 76/22 76/23 77/7 77/10 78/12 79/3 82/13 83/2 84/8 84/12 84/21 85/20 92/7 94/3 94/4 94/5 94/6 95/6 96/16 97/14 97/22 98/6 99/17 100/9 100/23 100/23 101/22 103/7 103/9 104/1 105/7 107/13 110/16 111/5 111/9 111/18 114/17 114/25 117/17 117/22 117/24 118/20 119/16 120/16 121/6 121/11 123/19 125/22 126/21 126/22 126/23 129/1 129/7 129/18 129/23 130/3 130/25 131/5 132/10 133/12 133/23 135/24 135/25 138/6 139/15 139/24 144/6 147/20 147/25 152/11 152/16 156/12 159/6 160/4 161/21 161/22 162/10 164/23 166/17 168/6 168/9 174/15 174/15 177/19 180/9</p>
--	--	---	--	--

A	35/13 37/1 37/17 38/18 41/10 47/18 47/20 50/23 51/12 53/6 56/19 57/12 58/2 58/7 59/13 62/20 63/11 66/6 74/12 74/12 85/20 86/6 92/12 92/14 93/13 94/15 96/22 105/11 121/18 141/11 143/4 143/12 146/16 147/1 154/25 161/8 175/5 182/21 185/5 187/21 190/19 190/21 193/16 195/18 197/9 197/14 198/15 201/15 asked [17] 41/18 72/3 92/16 95/8 105/8 106/18 120/24 128/15 149/21 155/2 168/22 169/19 172/11 174/14 175/5 197/12 203/9 asking [14] 28/11 56/4 66/25 85/17 86/3 86/9 95/10 97/25 100/1 100/3 105/2 106/23 174/23 192/11 aspect [2] 70/17 123/7 assert [1] 88/10 assess [5] 137/20 177/6 190/25 191/13 191/24 assessed [3] 159/12 176/19 176/23 assessing [4] 95/25 176/17 191/14 191/21 assessment [20] 93/22 99/7 99/15 99/19 100/4 102/1 102/5 102/22 156/12 156/16 161/24 176/14 176/18 177/1 177/4 177/17 177/20 179/23 197/24 199/8 assessments [2] 176/9 176/10 assist [7] 26/18 70/17 95/23 169/21 192/24 196/6 196/7 assistance [2] 94/19 94/19 associated [1] 188/14 Association [1] 185/6 assume [5] 22/17 42/9 127/22 140/7 189/19 assumptions [5] 21/20 21/24 22/16 23/11 31/16 assurance [11] 23/9 28/9 45/14 46/25 47/5	164/22 165/3 165/4 189/22 201/5 201/10 assured [2] 23/13 44/25 asymptomatic [3] 112/15 115/7 138/25 at [228] at all [7] 38/11 44/14 69/12 75/15 94/4 202/19 202/22 at November 2020 [1] 63/17 Atherton [6] 3/22 6/10 8/2 30/13 30/18 118/25 attached [1] 121/6 attend [1] 184/7 attendance [1] 170/20 attended [1] 73/17 attending [1] 83/10 attention [12] 28/13 41/11 43/15 44/3 47/23 69/12 81/6 112/6 112/12 124/5 135/6 154/24 attuned [1] 156/5 Audit [1] 40/16 Audit Wales [1] 40/16 auditing [1] 192/7 Auditor [1] 38/22 August [9] 72/8 72/12 72/15 86/14 92/18 92/20 93/7 93/7 137/5 authentic [1] 133/8 authorisation [1] 172/18 authorities [3] 37/6 40/8 169/20 automatically [1] 115/18 autumn [5] 10/6 53/5 73/7 169/18 183/19 availability [6] 113/4 114/11 114/13 167/25 195/21 196/5 available [41] 22/10 22/11 23/17 24/6 24/19 25/18 26/18 32/11 33/5 37/13 43/20 53/18 54/8 59/10 77/14 82/16 85/4 96/5 101/10 113/6 116/4 116/5 116/12 118/5 118/6 118/14 127/13 127/16 129/16 130/5 130/16 132/3 132/11 132/12 155/23 161/16 162/8 166/3 188/12 196/6 196/24 average [1] 159/23	avoid [7] 23/19 69/4 96/3 105/16 105/17 152/20 153/3 avoided [1] 172/21 awaiting [2] 83/25 144/16 aware [38] 5/21 27/4 30/4 30/19 45/22 48/8 50/9 77/8 77/18 78/12 78/15 78/19 78/20 79/3 79/8 80/7 105/19 113/24 113/25 123/10 123/12 130/23 132/5 132/6 136/19 142/20 159/20 160/21 162/3 162/9 164/10 183/3 185/21 186/4 201/13 201/14 202/3 203/11 awareness [1] 176/1 away [9] 8/5 20/7 25/13 68/11 95/20 95/22 106/7 146/1 184/3 awful [2] 40/20 118/4 B babies [3] 83/2 183/5 184/7 baby [3] 96/21 182/18 183/1 back [44] 1/10 7/9 10/7 12/24 13/16 17/5 19/12 20/14 32/6 37/19 38/24 52/13 56/16 60/10 65/23 68/24 73/19 81/11 81/24 83/20 84/23 88/16 92/25 93/2 93/4 101/4 119/2 120/23 121/18 122/8 123/13 123/13 143/18 173/21 182/9 183/14 189/13 189/20 192/11 194/9 197/7 199/4 201/6 201/8 background [2] 1/17 1/18 backlog [5] 12/13 13/8 144/16 146/20 170/10 bad [3] 68/12 68/13 79/9 badly [1] 174/10 bags [2] 43/17 44/6 balance [10] 81/12 82/6 82/8 82/11 82/18 83/9 143/22 143/24 154/20 200/18 balancing [1] 155/8 BAME [6] 46/15 74/15 74/21 75/2 75/4 76/14 BAPIO [1] 99/16 Baroness [15] 122/3	122/5 122/6 122/13 167/14 182/13 182/17 185/5 190/18 190/21 197/9 197/15 197/19 204/4 205/14 BARONESS ELUNED [2] 122/5 205/14 Baroness Morgan [11] 122/13 167/14 182/13 182/17 185/5 190/18 190/21 197/9 197/15 197/19 204/4 barrier [1] 101/25 base [2] 147/24 181/7 based [8] 31/6 32/11 51/14 91/6 101/8 101/9 103/19 159/1 baseline [1] 185/13 basing [1] 52/9 basis [9] 55/24 56/11 70/19 91/5 130/10 147/22 148/2 149/25 174/11 Bay [2] 8/12 63/25 be [228] beards [2] 46/6 46/16 became [14] 1/18 1/20 1/21 5/12 15/20 46/19 48/8 77/18 88/23 88/23 123/8 156/15 177/1 196/25 because [128] 3/11 5/9 5/15 7/6 8/17 8/19 9/9 11/14 15/12 15/21 20/22 21/4 21/7 22/5 23/15 25/1 25/10 26/4 26/9 28/5 29/6 29/20 30/8 30/25 33/22 34/8 34/21 35/7 35/25 36/19 37/7 37/11 37/16 40/4 42/9 43/12 44/16 45/13 46/8 49/17 50/13 50/19 52/21 53/1 53/7 54/14 55/6 55/10 56/13 58/25 59/13 59/22 61/13 62/11 65/7 65/14 68/4 69/2 69/18 71/7 72/17 72/23 73/4 74/10 76/10 78/8 79/12 79/20 79/21 81/21 85/8 85/16 91/2 91/21 91/24 93/20 94/4 95/5 103/11 103/24 104/11 107/16 108/25 111/19 113/13 113/22 117/21 119/2 123/21 127/4 128/17 132/15 133/6 133/10 138/6 139/13 142/20 146/1 147/22 148/1 150/1 152/8 152/17 152/18 156/3 157/20
----------	---	---	---	---

B	148/22 148/24 149/14 152/8 152/24 154/15 155/6 155/10 155/22 156/4 156/8 158/13 158/18 160/15 160/16 162/8 162/19 163/2 164/10 164/12 164/13 165/6 167/23 167/24 168/4 168/16 168/19 171/2 171/13 172/18 172/21 175/4 176/13 176/22 177/5 178/20 179/5 179/6 179/9 179/17 181/5 181/19 183/1 183/12 183/17 184/4 186/12 189/23 199/11 202/2 203/4 203/10 203/11 203/15 before [34] 5/14 18/1 22/19 33/18 35/6 35/25 47/19 48/10 49/4 49/8 54/17 70/8 70/12 77/8 78/10 87/16 88/22 88/22 107/23 109/8 132/20 133/7 140/20 155/4 156/25 161/12 167/6 169/2 171/20 177/1 178/2 180/16 180/18 180/19 before it [1] 78/10 began [1] 122/21 Beggs [1] 194/20 begin [2] 123/1 184/23 beginning [3] 85/5 160/18 182/25 behalf [12] 29/16 86/3 91/15 92/12 105/6 108/13 185/5 187/6 187/22 190/20 197/9 198/15 behaviour [1] 73/4 behavioural [1] 18/16 behind [3] 76/7 185/2 198/12 being [100] 1/20 3/10 5/5 10/20 15/5 15/9 21/9 22/16 24/4 24/23 30/15 30/24 31/2 32/21 32/24 34/8 36/15 40/6 41/5 41/18 41/20 41/24 41/25 42/12 42/17 43/21 44/2 44/6 46/2 46/24 46/24 47/12 49/5 49/7 49/22 50/4 52/16 52/17 52/20 64/6 64/21 65/15 65/17 66/16 66/20 71/22 73/12 73/21 76/23 77/25 78/1 80/8 80/10 82/5 82/13 82/16 83/6	87/18 89/8 108/21 109/13 111/24 112/23 114/1 114/3 114/7 114/10 117/2 119/1 120/21 126/4 130/14 134/11 137/25 147/25 151/22 152/21 154/23 155/2 156/20 156/25 157/14 157/24 158/4 162/25 164/11 165/2 175/18 175/20 181/10 184/2 184/14 186/5 189/9 190/4 190/8 191/3 196/11 202/19 203/9 beings [1] 204/6 believe [3] 35/14 100/12 108/22 below [3] 135/22 136/5 159/24 beneficial [1] 166/12 benefit [6] 14/13 29/25 73/10 87/8 125/5 143/19 benefits [4] 81/13 143/22 154/20 193/20 benign [1] 56/15 bereaved [8] 86/4 108/13 162/19 187/22 187/23 188/1 188/15 198/15 bereavement [7] 109/15 188/7 188/11 188/18 188/24 189/1 189/17 best [10] 23/17 57/1 98/8 103/16 106/24 107/3 118/14 180/2 193/6 199/16 best example [1] 103/16 better [19] 8/19 10/5 13/6 19/19 30/2 68/8 71/7 77/11 77/16 78/6 103/23 104/14 117/2 148/22 179/17 180/3 180/4 193/4 200/10 between [27] 5/24 21/22 23/6 24/8 27/5 27/11 34/9 54/18 64/11 64/12 64/13 65/12 67/18 81/13 89/24 92/4 100/19 105/2 119/14 129/14 131/3 131/8 143/10 143/22 158/19 166/16 179/13 between February [1] 89/24 Bevan [3] 21/3 60/24 61/6 beyond [2] 85/4 154/23 bidding [1] 35/2	big [4] 4/12 46/5 147/18 174/13 bigger [4] 5/7 26/9 35/7 39/17 biggest [2] 21/9 111/10 bin [2] 43/17 44/6 birth [6] 81/18 81/19 81/20 83/11 97/9 98/8 birthing [4] 143/8 143/10 143/11 143/14 bit [8] 33/6 38/8 64/2 93/10 156/1 156/6 194/9 195/13 black [8] 75/12 100/6 100/25 102/14 176/12 176/25 177/11 177/24 blame [1] 136/15 blanket [4] 80/8 81/1 162/13 164/11 Bliss [1] 183/17 blokes [1] 46/5 Blood [2] 4/23 4/25 blue [1] 34/6 bluntly [1] 40/11 BMA [2] 79/2 127/9 board [21] 12/7 17/14 22/6 24/22 25/2 27/12 35/25 40/3 63/23 64/17 80/17 98/19 120/18 124/19 126/1 135/16 138/4 164/23 168/11 176/23 201/8 boards [57] 2/15 9/18 9/20 10/17 11/12 16/24 17/6 17/10 18/4 21/2 21/14 25/25 27/6 27/23 32/18 36/15 40/7 50/8 56/1 56/25 60/10 66/3 66/17 67/3 68/22 70/19 78/18 80/20 97/3 97/19 98/19 105/16 114/8 117/17 117/18 120/3 120/5 124/15 125/23 136/16 137/7 139/5 142/1 142/6 147/22 148/20 149/8 157/4 157/10 157/13 158/20 176/19 177/6 178/12 185/24 201/6 203/21 boards' [1] 132/16 bodies [2] 2/14 135/25 body [4] 56/21 125/8 136/8 187/6 Bore [1] 1/12 borne [1] 77/6 both [26] 3/3 3/12 5/9 5/14 6/24 16/2 26/3 35/16 35/19 38/7 38/8 42/12 45/4 54/24 60/1 70/2 70/4 73/21 83/7	83/10 84/17 117/15 129/11 182/24 183/4 184/6 bothered [1] 13/21 bought [1] 195/10 box [1] 201/24 boxes [1] 73/23 Brace [3] 35/20 35/23 37/2 brand [1] 181/10 breach [2] 25/9 26/13 breached [4] 24/15 111/20 111/24 112/3 break [4] 47/19 57/16 57/20 167/11 breaking [2] 134/3 134/19 breathing [1] 174/12 breweries [1] 44/17 brief [3] 66/14 94/7 124/6 briefing [8] 18/10 63/12 64/19 65/1 67/13 135/2 135/9 203/7 briefings [2] 18/20 66/23 briefly [3] 6/19 31/8 96/24 Brif [1] 198/14 Brightling [3] 107/12 158/12 158/15 bring [3] 72/11 73/2 182/9 bringing [3] 43/14 65/23 81/14 brings [3] 85/1 134/4 149/15 brink [1] 26/1 broad [2] 124/15 190/24 broader [2] 47/8 178/9 broadly [4] 10/4 57/4 120/14 191/9 brother [1] 156/4 brought [18] 41/11 44/2 44/8 47/23 49/5 69/12 72/5 81/6 109/8 109/12 112/6 112/11 135/5 139/20 154/24 156/22 172/9 201/15 brown [3] 75/12 100/6 100/25 bruised [1] 79/24 bubbled [1] 7/25 budgets [1] 118/15 build [3] 22/8 119/9 178/6 building [4] 12/13 31/23 33/6 173/2 buildings [2] 19/18 71/9 built [2] 32/14 119/24
----------	--	--	--	--

B
bullet [1] 170/23
bundle [1] 201/17
burden [1] 121/19
burning [1] 34/22
bus [2] 77/25 101/17
busier [1] 127/24
business [4] 40/23
58/14 100/21 117/17
busy [1] 122/6
but [297]
buy [2] 40/24 40/25
buying [1] 43/17

C
cab [1] 101/23
cabinet [4] 1/20 5/12
144/2 178/4
call [5] 12/19 32/3
44/22 87/25 122/3
called [3] 48/18
138/13 187/5
calls [4] 20/13 168/4
168/4 170/20
Cambodia [1] 90/10
came [34] 4/4 7/22
8/22 8/23 25/22 26/1
29/10 34/11 34/12
36/13 37/3 45/10
46/18 78/9 79/14 80/3
90/8 90/22 94/24
114/2 118/11 123/2
134/20 134/21 144/1
144/14 145/23 146/4
151/10 158/4 169/23
190/4 190/8 195/19
campaign [2] 103/3
185/6
campaigns [1] 103/4
can [175] 2/23 2/25
4/13 5/6 6/1 6/23 7/1
7/3 7/5 7/6 7/7 7/10
7/11 8/7 9/5 11/18
12/12 12/17 12/25
13/8 13/10 13/13
15/18 16/3 16/5 16/9
16/22 21/11 23/9 23/9
24/13 27/4 28/9 29/11
29/14 31/13 32/16
32/20 33/25 34/4
35/13 37/19 38/5
38/20 39/3 39/5 39/10
41/1 41/10 41/12
42/23 43/5 43/8 47/18
47/20 48/8 50/23
51/12 53/16 54/21
57/24 57/25 58/1 58/2
58/7 60/12 60/15 63/9
63/11 63/18 63/24
71/11 72/4 74/12
76/10 78/21 78/22
82/15 83/9 85/12
85/25 86/2 92/17 95/1

99/1 99/3 101/2
103/23 106/9 106/23
111/8 115/17 118/7
120/10 121/3 121/20
122/8 122/11 123/1
124/9 125/1 125/3
125/20 125/22 127/1
127/2 127/6 127/12
127/17 127/20 128/24
129/9 129/9 129/12
129/15 129/18 129/21
130/3 130/15 134/24
135/9 135/11 135/15
136/5 141/1 141/11
143/4 144/11 146/1
146/16 147/1 147/18
149/18 151/7 152/16
155/12 155/24 157/17
158/6 159/7 160/2
160/8 160/11 163/20
164/8 167/1 167/14
168/20 169/24 170/2
170/16 171/15 175/13
179/10 180/5 181/11
181/12 181/23 183/11
184/12 188/16 191/11
191/14 191/24 192/13
193/19 194/11 195/14
196/12 199/14 199/19
203/17 203/20 204/8
204/9
can't [52] 7/3 8/11
14/12 14/14 14/21
19/3 20/10 28/4 33/22
34/13 37/16 48/13
51/15 52/12 59/9
64/25 66/1 67/21
70/18 71/9 74/3 74/3
78/16 79/20 81/23
82/5 85/14 87/9 95/3
117/1 119/9 119/10
121/18 131/18 132/4
132/10 147/17 147/17
150/7 163/6 163/6
173/13 173/20 173/25
175/12 177/2 184/23
187/13 190/7 194/11
202/5 203/25
cancelled [1] 129/4
cancer [2] 144/4
144/20
candour [1] 136/16
cannot [1] 29/15
Canopi [1] 175/25
capability [1] 170/25
capacity [50] 18/12
19/14 19/25 21/18
22/3 22/9 22/22 23/20
24/4 24/14 24/19 25/9
25/17 25/24 25/24
27/1 30/3 31/9 31/22
33/2 35/9 84/15 109/1
110/23 111/16 111/16
111/25 112/3 115/10

115/18 115/21 124/23
124/23 127/14 127/15
129/2 130/5 130/9
130/12 130/23 131/6
131/17 132/17 146/12
146/22 170/5 170/25
172/6 173/6 173/10
capital [8] 117/13
117/18 118/5 118/6
118/9 118/15 181/3
203/15
capture [2] 66/15
76/3
captured [1] 75/3
capturing [1] 101/8
Cardiff [9] 8/12 12/7
21/3 21/15 25/15
27/17 90/9 120/8
121/10
care [176] 3/14 9/7
9/10 9/17 9/25 10/10
10/22 12/20 13/20
14/12 15/2 15/10
16/14 18/1 18/12
18/13 18/23 19/1 19/7
19/15 19/25 20/1
21/23 22/1 22/11
22/22 23/10 23/14
24/17 25/14 26/23
26/24 27/5 27/11 28/2
28/9 28/14 28/15
28/18 28/21 29/2
29/12 29/18 29/22
29/23 30/6 31/4 32/2
33/8 33/11 33/12
33/13 33/15 33/21
37/8 41/18 49/15
49/21 49/24 49/25
50/3 50/4 50/17 50/19
50/21 50/21 51/10
52/1 52/2 52/10 53/14
53/14 53/15 53/24
63/15 65/4 67/7 73/2
76/14 83/10 83/25
83/25 84/12 84/13
91/23 97/9 97/20
105/18 107/3 108/14
108/18 108/22 110/1
110/23 111/12 111/20
112/4 112/9 114/21
114/23 115/6 115/23
115/24 123/13 123/14
128/18 128/23 129/16
129/17 129/19 129/24
129/24 130/3 130/4
130/5 130/14 130/17
130/25 131/1 131/2
131/3 131/7 131/11
131/12 132/6 132/9
142/21 142/21 143/15
144/14 144/18 144/23
144/24 144/24 144/25
145/3 145/12 145/13
145/17 145/21 146/17

146/19 147/3 147/17
147/18 148/8 148/11
148/12 148/19 149/16
150/1 150/5 150/8
150/8 152/1 158/16
159/16 160/11 160/12
166/9 166/13 173/19
177/14 181/5 181/6
181/12 181/21 184/3
184/14 185/6 185/8
186/7 188/24 189/1
197/21 197/23
care home [1]
115/23
careful [2] 72/21
149/20
Carey [8] 1/3 57/22
86/7 86/9 88/4 88/5
90/3 96/24
carried [1] 156/21
carry [2] 7/7 115/13
case [15] 18/12
18/20 18/24 20/2
22/13 22/14 22/25
31/19 32/4 137/13
142/17 164/20 165/8
202/6 202/19
cases [14] 43/21
63/20 63/21 63/22
63/23 113/19 115/12
117/17 136/14 138/1
142/12 144/20 170/20
188/21
cases/calls [1]
170/20
cash [1] 118/16
catching [1] 75/3
categories [1]
131/25
caught [1] 79/12
cause [4] 138/6
138/10 202/3 202/5
caused [8] 47/22
50/15 67/12 69/3
86/22 136/9 144/25
160/16
causes [4] 137/10
138/2 138/7 138/8
CBFJ [1] 201/19
cease [1] 9/17
CEDAR [2] 159/19
159/20
celebration [1] 76/4
central [7] 8/14 27/14
55/13 120/8 124/25
157/22 176/7
centralised [1]
125/15
centrally [2] 125/11
125/13
centre [3] 107/8
156/21 202/20
centres [4] 11/10
51/7 51/23 52/3

certain [2] 23/10
173/3
certainly [27] 8/1
34/20 47/10 50/20
52/14 52/15 52/18
57/2 60/10 61/5 74/9
80/13 81/4 83/14
83/22 87/24 88/5
108/1 112/11 117/5
126/2 126/5 130/10
136/19 151/13 156/25
197/17
certificates [1] 101/9
cetera [2] 21/16
21/16
chain [2] 58/24 59/22
chains [1] 88/13
chaired [1] 102/21
chairs [16] 2/24 3/20
11/25 20/15 26/7
36/14 59/22 59/22
61/17 66/2 66/3 66/17
67/24 78/22 110/12
126/2
challenge [28] 10/3
10/7 10/13 11/10
12/24 13/2 22/15 48/5
51/18 55/9 55/17 56/3
61/1 68/23 72/22
80/21 81/24 84/5
84/10 85/13 96/9
99/21 99/23 115/16
115/25 117/20 120/7
181/16
challenges [12] 2/25
3/16 8/10 12/23 13/10
15/6 31/18 36/8 36/11
117/6 124/3 147/15
challenging [2]
147/20 181/6
Chamber [2] 32/5
32/7
chance [2] 30/2 30/6
change [10] 8/15
8/17 8/19 15/25 80/22
98/13 131/25 150/23
181/14 193/13
changed [7] 33/6
88/1 111/14 111/15
161/10 161/12 184/11
changes [6] 109/19
119/21 141/2 160/12
183/20 184/9
changing [3] 11/16
157/20 157/21
chaos [2] 41/16 88/6
chapter [1] 66/15
characterisation [2]
105/24 106/11
charity [1] 183/17
Charles [2] 25/22
119/19
chasing [1] 165/7
cheap [1] 195/1

C	204/9	125/10	88/19 88/21 90/7 93/2
cheaper [1] 192/22	claims [1] 136/14	co-chairs [1] 59/22	101/4 114/9 127/10
check [2] 32/20	clean [1] 203/6	co-ordinate [1]	142/6 142/16 144/12
164/1	cleaner [1] 195/1	125/10	149/22 149/23 175/3
checking [2] 89/25	clear [21] 67/22	co-produce [1]	command [8] 6/19
90/1	80/18 115/5 120/16	106/25	7/18 7/24 8/8 120/1
chief [55] 2/25 3/20	130/14 144/8 144/19	CO2 [13] 190/21	120/8 125/1 125/9
3/23 3/23 7/21 11/25	145/10 150/12 150/23	190/24 191/6 191/10	comment [1] 53/10
20/15 22/6 23/4 26/7	157/17 160/25 161/25	191/12 192/9 192/10	commentators [1]
35/16 35/21 36/14	162/3 163/12 171/7	192/16 192/24 193/10	103/8
48/14 48/22 49/4	171/9 172/5 180/16	193/13 193/19 194/7	commented [1] 7/21
54/19 55/6 59/23	182/19 189/12	coating [1] 69/2	commercial [1]
59/23 60/1 60/2 60/3	cleared [3] 70/18	cognitive [1] 82/2	171/1
60/5 62/17 65/22	133/7 146/8	cohort [1] 154/12	commission [1]
66/13 67/24 73/17	clearer [1] 51/6	collaboration [1]	199/3
79/11 80/1 82/9 98/16	clearly [10] 3/17 5/10	8/22	commissioned [1]
98/17 98/17 110/9	18/21 39/13 59/13	collaborative [2] 8/5	96/25
110/9 110/10 110/11	134/23 144/25 163/1	85/11	Commissioner [4]
110/11 110/12 113/2	163/12 165/8	collapse [1] 89/6	80/11 84/18 84/18
116/9 126/11 126/12	clinic [6] 54/1 107/2	collapses [1] 33/19	168/13
140/18 151/14 151/22	107/8 107/14 156/20	collapsing [1] 91/25	committed [1] 170/8
152/22 153/2 153/14	158/17	collate [1] 57/1	committee [3]
153/22 154/14 168/12	clinical [22] 6/5 31/6	collated [1] 56/2	146/19 168/2 168/16
182/23	54/14 54/16 64/15	colleagues [1]	committee's [1]
chief exec [1] 60/3	64/24 65/13 65/18	160/23	114/22
chief executive [1]	105/21 105/22 106/3	collect [1] 166/25	common [5] 53/3
110/9	107/25 108/1 108/3	collected [5] 52/16	153/4 166/21 166/25
chief executives [1]	132/2 156/7 158/23	55/25 76/22 131/14	167/1
2/25	164/24 167/4 169/11	202/25	common-sense [1]
childbirth [1] 101/1	197/23 198/5	collecting [4] 56/22	153/4
children [4] 19/4	clinically [20] 11/7	56/23 57/4 57/5	commonly [1] 48/24
92/25 93/4 195/11	69/8 69/9 69/14 92/12	collection [5] 76/15	communicate [1]
China [1] 90/10	95/24 95/24 96/11	116/16 200/23 202/9	141/18
Chloe [1] 148/5	139/25 140/4 151/25	202/10	communicated [3]
choice [15] 23/17	153/13 155/1 155/9	college [13] 5/21	87/11 102/17 120/20
31/6 87/15 94/1 94/24	190/20 192/2 192/12	5/25 6/2 6/7 6/8 6/12	communication [5]
95/17 108/5 108/5	193/20 196/18 198/6	6/14 6/15 7/17 12/11	94/21 103/16 141/12
109/9 113/7 113/13	clinician [1] 161/23	134/20 193/9 203/6	163/19 165/17
114/1 118/3 118/14	clinicians [6] 30/23	colleges [6] 3/24	communities [8]
120/22	109/8 161/18 165/3	3/25 6/8 6/11 79/2	25/4 25/4 74/17 75/2
choices [24] 8/24	165/13 166/4	110/14	75/13 101/7 102/12
10/15 11/13 23/16	clinics [8] 53/9	column [2] 201/19	103/22
30/10 30/24 31/2	106/18 106/20 107/15	201/20	community [18]
42/19 50/9 77/20 78/7	107/18 107/20 158/23	combating [1] 196/6	24/18 49/15 50/4
84/15 87/17 94/13	160/10	combination [1] 99/8	63/18 64/16 64/18
96/13 104/1 104/6	close [9] 24/22 25/22	come [29] 15/17 20/5	66/8 102/15 103/9
109/12 110/18 111/6	26/1 26/5 51/11	21/6 29/20 30/17 46/9	116/14 117/4 123/5
118/7 120/16 120/17	131/17 153/6 159/7	57/2 74/3 80/18 83/8	151/21 152/6 155/20
121/10	168/24	87/1 87/22 89/14	158/25 170/20 173/24
Chris [2] 26/4 178/17	close-set [1] 153/6	98/16 102/10 103/19	comorbidities [3]
Chris Jones [1] 26/4	closely [1] 130/11	120/23 121/18 148/23	69/15 101/20 104/17
Christmas [2] 195/7	closing [2] 119/11	155/12 161/20 161/22	comparators [1]
195/8	151/19	162/11 174/22 174/25	19/15
circulating [1] 195/2	cluster [8] 60/24	175/20 189/13 189/20	compare [2] 11/2
circulation [1] 68/5	71/17 107/17 137/10	195/12	119/4
circumstances [5]	138/3 198/22 199/22	comes [10] 10/7 17/5	compared [6] 19/14
121/3 142/2 182/7	202/7	23/1 25/10 34/1 67/8	43/2 100/8 146/25
183/11 186/6	CMO [6] 62/16 80/19	198/6 200/11 200/15	148/9 192/17
cities [3] 144/22	94/23 94/24 155/10	200/17	comparison [1]
147/13 147/18	164/17	comfortable [4] 14/3	179/22
civil [3] 123/23	CMO's [1] 96/5	36/21 38/12 104/2	comparisons [1]
136/14 169/20	CNO [2] 80/20	coming [22] 1/10	179/25
claim [2] 136/10	164/17	3/11 16/19 21/5 22/3	compassionate [2]
	co [3] 59/22 106/25	24/3 28/25 33/1 51/1	163/18 165/17
			compelling [1]
			166/17
			competency [3]
			165/11 165/13 166/3
			complaining [1]
			163/5
			complaint [1] 112/7
			Complete [1] 41/16
			completed [1] 75/9
			completeness [1]
			201/7
			complex [3] 107/16
			184/19 198/4
			compliance [3]
			120/11 176/20 176/21
			complied [1] 163/2
			comprehensive [2]
			178/7 196/17
			compromise [2]
			119/12 119/13
			compromised [2]
			12/5 12/16
			compromises [1]
			111/7
			concentrated [1]
			147/6
			concentration [1]
			25/3
			concern [12] 3/9
			18/18 34/21 37/10
			43/12 44/7 44/14 45/1
			60/4 90/13 90/23
			202/6
			concerned [17]
			13/25 36/16 45/6 66/4
			72/17 81/2 84/16
			123/15 123/17 138/21
			140/13 152/18 162/24
			163/10 163/10 177/11
			191/4
			concerns [24] 3/20
			45/15 46/23 60/6
			72/16 73/11 80/8
			80/10 80/12 86/16
			86/25 94/16 103/6
			106/17 106/21 128/23
			153/11 154/5 154/23
			157/11 162/13 162/18
			164/7 196/3
			concluded [2] 97/1
			99/7
			conclusion [2] 99/10
			138/17
			condition [9] 48/1
			50/14 50/20 53/3
			55/10 56/15 60/19
			157/18 198/9
			conditions [6] 60/16
			106/2 144/17 191/18
			193/14 198/7
			conducted [1] 110/2
			conference [1] 17/21
			confidence [8] 41/4
			70/7 93/10 103/2

C	contacts [2] 145/4 152/2	coped [1] 29/9	42/21 82/20 82/21 95/15 164/6	135/13 135/21 135/24 137/3 140/1 140/6
confidence... [4] 103/5 152/10 152/15 153/25	context [6] 11/11 128/10 128/25 145/7 182/20 192/21	coping [4] 27/9 27/16 28/23 133/13	course [16] 1/21 16/4 18/23 20/18 22/13 27/6 34/18 37/8 37/24 55/7 61/23 71/10 78/16 98/7 154/2 154/15	144/17 155/21 170/10 176/12 178/13 178/16 187/22 188/3 191/2 191/15 191/21 191/24 195/2 195/22 196/6 196/25 198/15 203/7
confirm [1] 112/14	contexts [2] 11/4 17/6	copy [2] 1/15 83/18	covered [5] 10/1 38/9 75/24 85/10 87/2	CPAP [5] 31/5 108/24 131/12 131/17 131/18
confirmation [1] 164/21	contingency [1] 12/18	core [4] 84/8 85/22 100/14 175/13	cover [3] 1/14 58/7 80/5	CPR [1] 166/14
conflating [1] 111/23	continuation [2] 12/20 150/4	Coronavirus [2] 37/25 38/2	covers [1] 84/6	create [2] 40/10 141/9
conflicted [1] 105/21	continue [10] 95/1 123/10 145/21 152/3 152/24 153/1 162/1 170/8 173/6 186/8	correct [28] 1/22 1/23 1/25 2/7 2/12 2/16 2/17 2/21 2/22 5/12 18/5 19/23 32/18 36/7 36/8 39/16 72/8 86/19 91/8 122/15 122/16 122/20 122/25 157/5 167/21 167/22 169/14 169/15	Covid [141] 2/5 8/1 9/21 12/3 12/4 25/4 33/12 45/19 47/20 48/11 48/17 48/18 48/25 49/12 50/11 50/13 50/16 51/5 51/9 51/18 51/20 51/20 52/11 52/15 52/19 53/9 54/1 54/5 54/20 54/23 54/25 55/1 55/15 56/5 57/9 63/20 64/3 64/5 64/7 68/7 69/21 70/7 74/9 74/15 74/21 74/25 75/5 77/19 78/1 78/13 86/4 92/23 93/7 96/10 102/16 105/7 105/12 105/15 105/23 106/17 106/18 106/18 106/20 107/8 107/11 107/13 107/15 107/17 108/13 114/15 114/22 123/4 123/4 123/15 129/18 129/19 129/22 129/23 131/8 131/16 131/19 132/1 132/3 135/13 135/21 135/24 137/3 137/8 138/25 140/1 140/2 140/6 142/2 144/17 151/22 155/12 155/17 155/21 156/8 156/13 156/17 156/18 157/14 157/16 157/17 158/2 158/12 158/16 158/20 158/22 159/23 160/6 160/10 162/18 170/10 174/18 176/12 177/13 178/13 178/16 179/17 179/24 185/23 187/22 188/3 188/15 191/2 191/15 191/21 191/24 195/2 195/22 196/6 196/19 196/25 197/10 197/20 197/22 198/3 198/15 203/7	created [4] 24/4 32/9 33/2 173/23
confusion [2] 86/23 105/1	continues [1] 145/18	correctly [3] 14/25 15/1 29/1	crews [2] 169/14 170/15	creating [1] 170/21
connection [1] 74/6	continuing [2] 93/9 171/8	corridors [1] 13/20	CRITCON [2] 25/23 128/9	creating significant [1] 170/21
consequence [1] 170/19	contract [3] 154/4 161/10 161/13	cost [4] 25/10 136/13 158/24 195/15	critical [46] 8/3 18/12 18/13 18/23 19/1 19/7 19/15 19/25 20/1 21/23 22/1 22/21 23/10 23/14 24/17 26/23 26/24 27/5 27/11 29/12 29/18 29/23 31/4 108/14 110/1 110/23 111/20 112/9 116/10 129/16 129/17 129/19 129/24 129/24 130/3 130/4 130/5 130/14 130/17 130/25 131/7 131/11 131/12 132/6 132/9 177/14	crews [2] 169/14 170/15
consequences [8] 47/24 48/9 48/25 51/17 62/24 65/19 149/4 171/7	contracted [1] 140/5	cost-effectiveness [1] 158/24	Costs [1] 171/22	critically [2] 22/11 92/5
consequent [1] 188/16	contracting [3] 140/2 152/21 153/7	Costs [1] 171/22	cough [1] 62/1	cultural [4] 98/4 98/12 102/24 121/8
consequently [1] 148/15	contracts [1] 89/8	could [61] 4/16 7/7 8/19 14/9 15/11 16/6 21/7 23/18 27/18 33/23 34/22 44/25 46/12 63/2 70/8 74/18 74/22 82/14 82/16 82/17 84/4 85/2 89/10 94/17 95/23 96/3 102/6 102/7 103/1 103/2 103/6 103/20 113/14 114/11 114/19 116/13 128/16 133/10 137/23 140/14 148/23 154/3 160/13 160/16 168/23 177/8 178/5 179/14 179/14 179/17 180/13 182/9 186/11 189/20 192/1 196/7 200/3 200/8 200/9 201/23 202/25	coughing [1] 93/23	culturally [3] 98/10 102/17 103/17
consider [18] 15/18 19/6 29/1 69/7 71/2 81/11 93/22 94/17 95/22 104/20 108/4 140/15 141/11 143/13 143/18 152/4 153/18 194/3	contributed [2] 45/4 99/8	couldn't [8] 33/8 36/20 52/21 70/22 78/5 95/13 96/10 197/1	country [7] 13/18 21/9 43/11 140/22 142/3 147/6 185/22	culture [4] 68/22 85/15 120/12 136/15
consideration [8] 17/16 97/15 116/14 145/19 154/8 158/22 175/5 203/22	contribution [1] 142/15	Council [1] 166/7	counsellor [1] 166/7	current [5] 3/7 84/24 108/5 111/15 179/1
considered [7] 106/5 154/14 162/25 166/11 177/17 191/8 197/1	control [16] 6/19 7/18 7/24 8/9 60/8 82/17 93/20 119/6 119/25 120/4 120/8 125/2 125/9 135/1 139/23 193/11	counsel [8] 1/9 28/10 105/7 112/12 122/10 197/11 205/4 205/15	counsel's [1] 6/24	currently [1] 149/1
considering [2] 123/1 171/6	convenient [2] 51/24 181/24	counselled [4] 132/18 143/9 143/15 149/17	counted [4] 132/18 143/9 143/15 149/17	cusps [1] 65/8
consistency [1] 10/11	conveniently [1] 57/15	countries [2] 72/7 166/16	country [7] 13/18 21/9 43/11 140/22 142/3 147/6 185/22	CVF [1] 196/7
consistent [4] 56/4 61/7 129/6 129/8	convening [1] 8/24	couple [6] 20/17	Covid-19 [41] 45/19 49/12 51/5 51/9 64/7 74/15 74/21 74/25 75/5 86/4 102/16 108/13 114/22 123/4 129/18 129/19 131/19	Cwm [7] 21/3 24/25 25/21 25/22 26/1 63/24 116/9
consistently [6] 9/15 42/21 128/2 174/14 174/23 188/19	conversation [16] 4/12 24/1 24/8 42/3 45/10 48/15 48/21 49/3 49/6 55/2 66/2 73/15 80/23 87/12 90/22 92/2			Cwm Taf [1] 24/25
constituents [1] 154/23	conversations [35] 3/21 3/22 3/23 21/21 22/23 23/6 27/10 30/4 35/16 35/17 45/13 45/16 46/18 47/1 47/12 48/14 50/11 54/24 65/21 66/7 66/10 66/18 66/23 67/24 73/18 77/22 79/2 79/13 80/2 80/3 90/4 91/12 95/14 110/8 162/6			Cymru [3] 108/13 198/16 201/19
constraints [1] 128/4	conveying [1] 97/6			
construct [2] 93/20 95/5	cope [3] 14/21 27/20 27/22			
consult [1] 186/25				
consultant [3] 41/14 88/7 88/22				
consultant's [1] 88/6				
consultants [3] 43/7 61/24 193/11				
consultation [2] 162/24 186/17				
consultations [3] 161/3 161/4 181/19				
contact [8] 23/3 23/5 43/6 73/24 74/5 74/8 82/24 136/8				

D	112/21 114/16 122/23 153/8 157/11 172/18	10/14 11/12 74/1 115/23 117/25	developments [1] 187/8	199/23 200/16 200/25 202/24 203/21
data [71] 24/7 24/11 30/14 52/15 55/25 56/22 57/2 57/4 57/5 64/2 67/2 74/12 74/13 75/1 75/8 75/9 75/16 75/17 75/19 75/20 75/22 76/1 76/4 76/13 76/14 76/21 76/24 77/1 77/5 77/14 77/17 77/18 77/23 78/2 78/3 78/6 78/11 101/8 101/9 101/12 109/4 109/23 110/3 110/7 110/15 110/18 110/21 110/24 116/10 116/16 127/12 129/13 131/13 131/25 132/19 133/21 135/11 135/16 166/25 170/3 178/21 200/6 200/22 200/25 201/7 202/9 202/10 202/16 202/22 202/24 203/3	decide [1] 87/7 decided [7] 29/22 49/13 52/8 87/9 88/1 94/10 95/19 deciding [1] 154/22 decision [17] 8/11 9/9 9/16 49/16 52/10 77/17 87/6 87/14 92/17 93/13 93/25 101/11 106/19 107/24 107/25 124/14 195/21 decision-maker [1] 107/25 decision-making [2] 101/11 124/14 decisions [15] 2/16 30/15 32/17 73/8 75/2 77/15 164/23 165/6 184/21 185/14 185/18 186/5 186/22 187/11 193/25 declaring [1] 25/23 decline [1] 169/6 deficiencies [2] 201/13 202/16 definite [2] 63/20 135/13 definitely [20] 13/6 28/4 28/5 46/1 48/21 49/6 82/10 103/14 104/9 104/17 133/22 134/16 143/16 146/14 176/1 177/17 184/10 186/1 187/12 196/1 definitively [2] 64/25 138/9 degree [7] 75/11 86/7 105/1 141/25 152/9 153/25 159/13 delay [4] 9/11 112/18 113/21 184/13 delayed [4] 147/15 148/9 170/20 173/18 delays [3] 128/4 148/16 167/21 delegating [1] 2/14 deliberate [2] 149/6 184/24 deliberately [1] 202/13 deliver [20] 11/13 22/11 42/8 49/7 50/8 51/22 62/18 71/10 76/9 102/21 106/23 106/24 107/3 111/11 113/14 115/18 116/1 116/3 117/1 118/2 delivered [10] 8/19 49/14 49/22 50/17 50/21 66/24 91/16 119/16 126/4 171/20 delivering [6] 4/15	delivery [8] 10/9 44/13 54/11 148/7 168/8 168/24 187/4 188/23 demand [5] 29/10 105/18 145/6 170/5 170/6 demanding [1] 8/18 demands [3] 26/20 116/18 147/4 demonstrates [1] 165/7 depart [1] 141/7 department [6] 43/25 78/11 84/3 177/21 185/16 196/2 departments [3] 5/11 132/8 133/4 dependency [1] 131/2 depends [1] 177/18 deployed [1] 59/11 deploying [1] 67/4 depot [1] 169/13 depots [2] 37/6 37/7 deprived [2] 146/23 146/25 deputy [5] 26/4 35/21 59/23 73/16 110/10 dermatologist [1] 181/22 describe [1] 184/23 describing [1] 134/12 designing [1] 192/7 desk [1] 169/12 despite [4] 29/21 64/18 152/21 186/6 destroyed [1] 38/11 detail [7] 28/13 75/24 76/20 97/25 98/1 132/2 201/12 detailed [4] 96/1 126/3 126/16 137/15 details [2] 149/21 163/3 determinants [1] 100/2 determine [2] 161/19 162/10 deterred [1] 136/16 develop [3] 51/7 115/5 168/13 developed [13] 68/22 76/1 125/16 126/19 137/6 147/21 147/25 148/1 156/25 157/2 157/3 166/8 181/11 developing [2] 147/20 176/14 development [1] 155/20	devices [6] 65/8 65/9 112/25 113/4 113/5 116/4 devolved [4] 86/24 87/7 88/2 102/4 DGH [2] 71/8 71/12 DHSC [1] 199/9 diagnosed [3] 55/14 63/21 63/22 diagnosis [3] 144/3 144/16 168/7 did [164] 3/18 6/3 10/16 11/18 11/21 12/1 13/13 14/6 14/8 14/19 15/16 18/11 19/18 19/24 20/19 20/21 22/24 23/20 23/21 24/25 27/23 28/4 30/24 31/14 32/20 33/7 34/4 36/7 36/11 38/5 39/18 41/23 42/14 42/16 42/23 43/6 44/7 45/13 45/23 45/23 46/1 46/14 46/17 46/23 46/25 50/3 51/6 54/3 54/18 59/19 59/20 64/20 64/25 67/18 69/6 70/14 70/18 70/20 70/23 72/6 72/7 75/6 76/16 79/9 80/9 80/13 80/17 83/4 86/23 87/1 87/20 87/21 89/3 89/5 89/7 89/23 91/9 94/14 95/22 100/3 101/16 102/2 102/13 102/19 103/3 103/14 108/16 109/20 110/23 113/12 114/6 118/19 118/19 118/21 123/9 123/21 126/14 126/15 127/8 131/25 132/22 133/14 133/17 133/21 134/9 134/13 138/7 139/6 140/15 140/19 141/11 142/13 144/15 146/10 146/11 149/9 150/10 150/18 150/20 152/4 153/18 154/3 154/24 156/19 157/10 157/11 161/5 161/14 162/3 163/3 165/10 165/15 165/19 172/2 173/6 173/7 174/22 174/25 175/11 175/11 176/20 177/23 178/12 178/14 180/4 181/13 182/1 182/2 182/6 185/16 186/24 187/10 188/20 191/5 191/5 198/18 199/3 199/7 199/9	didn't [48] 3/4 3/11 6/1 12/23 14/1 15/1 25/4 25/9 26/13 27/7 28/5 29/25 30/5 38/6 38/6 39/3 41/7 42/2 44/13 55/16 59/21 60/7 62/18 62/18 64/5 72/14 73/6 80/12 96/14 101/12 103/5 112/11 112/24 116/2 125/14 128/15 146/13 150/9 150/11 150/21 158/5 162/9 163/16 165/4 192/8 194/3 197/25 199/22 die [1] 14/16 died [1] 29/21 difference [11] 34/9 34/10 45/14 46/11 68/20 112/10 146/15 168/9 173/1 179/15 195/17 differences [1] 185/21 different [74] 4/4 4/5 11/3 11/10 17/5 17/9 17/10 17/12 18/6 18/6 20/13 25/12 25/12 26/10 28/22 29/23 31/4 31/5 31/7 31/25 32/10 33/10 34/2 35/9 35/10 35/18 36/4 38/13 46/4 53/22 54/8 54/11 55/12 57/14 60/17 69/6 76/4 77/17 77/18 78/7 78/11 78/25 82/13 88/25 92/4 98/7 100/10 100/19 100/23 100/25 101/22 102/24 102/25 103/10 104/16 104/16 109/9 111/23 112/8 114/1 117/2 120/16 120/17 120/25 127/9 128/8 128/9 134/12 156/21 166/18 166/22 166/23 179/25 180/4 differential [1] 78/8 differentiate [1] 131/3 differentiating [1] 116/14 differentiation [1] 131/1 differently [7] 9/4 55/10 144/7 180/11 180/13 194/12 194/13 differing [1] 193/13 difficult [27] 8/16 18/15 37/24 65/14 73/3 74/4 97/9 124/6 126/25 127/4 128/2

D	180/18	166/10 199/5 200/11	75/18 79/4 81/16 82/5	15/19 16/3 24/14
difficult... [16] 132/20	disagree [1] 110/19	DNACPRs [6] 80/6	82/13 82/14 82/16	24/16 24/16 26/15
138/5 138/10 139/15	disappointing [1] 195/8	80/8 80/12 80/15	84/3 95/10 98/11	27/6 63/19 70/1 78/9
139/17 139/23 144/23	disaster [1] 23/18	80/23 164/11	101/15 114/3 114/10	84/2 97/3 99/12
147/10 147/13 162/6	disbenefits [1] 154/21	do [210]	125/11 137/17 144/7	101/11 118/17 118/22
173/9 175/4 179/23	discharge [5] 16/16	doctor [4] 29/12	160/17 163/15 178/5	119/11 125/4 135/18
181/6 182/6 193/25	16/17 70/5 70/5 126/9	29/18 108/1 110/1	179/5 179/9 179/16	149/17 151/12 160/12
difficulties [10] 41/9	discharged [1] 2/13	document [10] 42/16	179/17 180/2 180/11	163/24 167/16 169/18
56/20 56/23 97/5	disco [1] 153/4	60/23 67/22 76/10	180/13 189/11 189/12	177/22 178/22 187/4
120/4 132/7 150/9	discomfort [1] 11/15	114/20 115/1 148/11	189/19 190/1 194/13	191/4 198/19 199/13
162/4 196/9 196/11	discouraging [1] 105/20	148/13 176/16 201/23	200/13 203/17	during September
difficulty [3] 41/10	discover [1] 150/18	documentary [1] 67/21	door [2] 24/4 173/21	2020 [1] 24/16
186/23 202/8	discrete [3] 71/25	documents [4] 52/13	dotted [2] 190/23	duties [3] 74/11
digital [2] 166/21	83/17 103/4	52/22 66/21 66/22	194/19	122/8 140/9
181/17	discretion [1] 124/16	does [19] 13/15	double [1] 21/18	duty [1] 2/14
dignified [1] 13/21	discretionary [2] 117/18 184/4	23/25 40/14 42/7 49/2	doubt [1] 3/17	dying [2] 14/15 75/3
dilution [1] 27/2	discuss [4] 6/14 12/1	55/22 57/6 71/5 85/18	down [19] 9/17 16/19	
dim [1] 7/14	25/7 27/12	98/16 104/5 107/7	32/1 33/7 33/11 33/21	E
diminish [1] 72/2	discussed [7] 60/5	109/23 109/23 111/5	39/24 64/1 129/5	each [7] 24/2 35/3
diminished [1] 28/14	79/11 106/16 119/25	111/20 128/24 170/6	134/3 134/19 149/23	37/9 40/3 64/6 118/13
Diolch [4] 121/11	140/18 144/2 178/3	178/15	160/19 165/8 168/24	164/20
121/21 204/1 204/11	discussion [5] 17/2	doesn't [23] 13/22	174/12 174/23 174/25	earlier [25] 20/14
direct [16] 17/3 23/9	17/16 32/25 87/18	28/16 66/9 80/22	201/24	22/2 63/3 72/14 77/20
30/9 41/21 46/25	162/20	83/13 103/11 106/3	Dr [24] 2/18 3/21	87/11 88/16 101/17
68/18 73/15 73/18	discussions [2] 87/21 106/13	106/25 112/10 115/17	3/22 10/1 19/21 21/22	108/15 109/25 112/17
82/24 110/7 110/13	disease [5] 29/21	116/1 120/10 120/11	22/4 22/22 23/3 23/24	116/5 117/6 119/2
125/7 125/18 170/19	60/18 63/5 75/3 198/5	120/12 120/20 120/21	24/9 26/3 30/13 30/18	120/24 129/11 131/14
183/4 203/21	diseases [1] 104/16	125/17 125/18 130/1	30/20 31/17 32/25	143/17 155/23 183/9
directing [1] 9/20	dishonest [1] 23/13	130/24 131/14 136/21	37/1 38/1 39/24 42/4	186/14 188/20 200/16
direction [8] 9/18	disillusioned [1] 174/20	145/25	114/5 117/14 118/25	200/19 203/19
10/20 11/19 11/22	dismantled [1] 154/15	doing [35] 3/9 17/1	Dr Atherton [3] 3/22	earliest [1] 189/17
16/23 124/18 150/12	disparity [1] 100/18	25/8 27/9 27/10 28/15	30/18 118/25	early [7] 34/21 41/1
203/23	dispel [1] 160/17	31/20 35/23 47/2 47/4	Dr Goodall [16] 2/18	41/14 63/6 72/23
directions [4] 2/19	disproportionate [3] 74/16 99/18 101/6	57/11 63/4 65/20	3/21 19/21 21/22	91/23 118/3
10/2 120/10 125/21	disproportionately [1] 146/24	75/25 78/5 79/18 82/1	22/22 23/3 24/9 26/3	early April [1] 34/21
directive [6] 8/6 8/9	disrupted [1] 83/24	87/8 110/16 112/5	30/13 31/17 32/25	early weeks [1] 41/1
9/2 9/6 18/3 95/13	disservice [1] 158/21	139/22 161/2 161/2	37/1 38/1 39/24 42/4	ease [1] 94/17
directives [1] 8/22	64/23 65/13 139/19	161/3 165/12 173/22	117/14	easier [2] 119/7
directly [9] 10/15	152/3	174/15 174/24 179/12	Dr Goodall's [3] 10/1	150/6
31/2 36/1 60/3 66/2	distilleries [1] 44/17	183/12 192/7 194/8	22/4 23/24	easiest [1] 44/16
67/23 89/4 96/6	distinction [1] 143/10	194/12 194/14 195/5	Dr Kloer [2] 30/20	easily [1] 53/15
196/21	143/10	don't [49] 5/5 6/13	114/5	east [3] 17/8 17/11
director [9] 23/4	distress [1] 50/15	10/11 11/15 13/7	draw [2] 62/3 185/8	21/2
25/15 35/21 124/2	distributed [1] 40/9	17/24 18/2 18/9 20/8	drawn [3] 4/13 4/17	easy [2] 68/11 92/1
124/20 126/12 171/11	distribution [4] 36/9	21/14 21/17 22/15	54/13	eat [1] 180/25
172/3 179/1	37/4 88/20 90/1	22/24 33/16 35/22	draws [1] 70/2	ECMO [1] 108/25
director general [7]	district [3] 71/12	37/1 42/10 46/9 47/11	drew [1] 70/9	economy [1] 95/10
23/4 124/2 124/20	71/14 119/4	47/23 52/3 54/13 59/6	drive [1] 170/12	education [1] 180/24
126/12 171/11 172/3	diversity [1] 76/5	61/23 62/25 69/13	driven [4] 60/25	effect [3] 59/14 78/25
179/1	divide [1] 52/8	88/3 89/10 91/16	110/7 125/13 149/2	104/16
directors [9] 12/7	DNACPR [13] 162/13	106/2 106/6 106/10	driver [2] 77/25	effective [4] 153/13
30/18 30/19 62/17	162/19 162/22 162/24	109/19 133/12 133/22	77/25	154/7 157/24 177/5
62/17 68/21 80/2	163/2 164/7 164/13	134/13 138/15 144/22	drivers [15] 101/17	effectively [8] 67/16
80/21 201/8	165/6 165/14 165/21	147/23 153/4 156/24	101/17 101/23 101/24	106/10 123/24 125/20
disability [9] 9/13		157/18 161/20 169/2	134/2 169/21 170/11	132/17 152/23 159/17
72/17 73/12 81/1 84/7		174/2 177/9 184/15	171/12 171/13 171/25	189/9
84/7 84/19 86/16		186/18 200/2	172/4 172/14 172/19	effectiveness [2]
96/25		donated [1] 43/19	172/20 173/12	158/24 199/8
disabled [10] 83/19		24/20 27/19 28/2 30/7	DT [1] 43/25	effects [2] 47/22
83/21 83/24 84/3 84/5		33/9 38/23 42/18 46/3	dual [1] 91/4	155/21
96/23 97/4 97/5 98/13		46/24 47/15 49/7	due [7] 1/21 18/23	efficiency [3] 10/11
98/15		66/12 66/16 68/14	113/15 145/10 167/20	11/9 12/15
disadvantaged [1]			184/13 193/13	efficient [1] 117/25
			during [33] 5/9 8/5	effort [2] 90/18

E	enable [2] 81/17 145/21	entirely [5] 70/11 71/10 160/15 180/20 198/9	101/8 101/9	exact [1] 48/13
effort... [1] 103/13	encourage [1] 10/21	entry [2] 69/25 70/4	European [1] 19/15	exactly [6] 19/3
efforts [1] 140/3	encouraging [1] 195/1	environment [3] 64/7 111/9 191/2	evaluation [2] 159/19 159/20	38/18 39/4 138/6 149/6 189/25
either [12] 5/24 12/19 27/5 28/11 83/25 84/14 87/7 92/2 125/6 151/17 200/24 201/21	end [27] 5/15 9/6 34/20 53/25 57/13 58/6 58/19 58/22 59/8 62/8 66/19 72/11 90/24 90/25 92/18 93/7 93/15 93/19 120/20 138/19 167/7 172/9 172/19 174/20 190/2 191/11 195/20	environments [1] 153/6	Evans [4] 107/13 153/9 158/12 158/15	example [48] 4/3 4/16 4/22 6/15 10/25 17/9 17/24 18/2 23/21 27/17 33/12 39/9 44/16 49/4 70/16 71/18 71/23 78/6 83/8 84/11 87/5 89/1 94/7 94/18 95/4 96/1 97/5 100/25 101/16 101/23 102/1 103/15 103/16 109/2 109/25 112/7 118/8 119/1 119/19 125/12 127/17 131/12 139/1 147/9 154/10 179/5 184/13 187/2
elective [27] 6/17 9/7 9/10 9/17 9/19 9/25 10/22 12/12 12/20 13/1 18/1 33/13 33/15 34/1 144/13 144/18 145/20 145/21 146/17 147/3 148/8 148/11 148/19 148/21 149/16 150/5 170/9	ended [3] 44/18 72/10 123/4	envisaged [3] 52/20 116/3 119/23	even [30] 5/18 7/22 9/2 11/16 14/22 15/14 19/9 23/16 31/1 37/12 39/2 45/5 47/23 48/2 48/10 53/7 63/2 68/6 68/7 69/17 73/18 89/1 100/6 100/20 112/3 121/9 129/7 134/1 146/10 186/3	event [1] 17/2
element [1] 35/1	ending [5] 72/22 86/21 94/18 196/3 197/2	equipped [1] 50/12	eventually [6] 40/5 41/2 43/4 73/23 91/19 92/3	eventually [6] 40/5
eligible [1] 93/16	energy [1] 90/17	equivalent [4] 110/1 148/14 170/14 171/21	ever [5] 6/13 7/25 126/15 131/15 195/8	examples [9] 3/1 4/22 24/7 80/13 102/23 108/20 198/17 198/20 199/10
else [6] 3/18 22/10 51/25 104/5 109/16 187/15	enforce [1] 10/21	escalated [4] 29/22 29/25 108/21 108/24	every [19] 5/16 5/18 8/11 10/18 14/17 14/20 67/5 98/13 100/6 103/24 137/13 137/14 137/24 157/4 160/21 161/8 165/8 184/21 199/23	excessive [1] 167/18
elsewhere [5] 86/13 86/21 150/10 161/12 186/20	enforced [1] 64/21	escalation [1] 128/20	essential [3] 63/8 90/10 177/20	exclude [1] 185/18
Eluned [4] 122/3 122/5 122/12 205/14	engage [2] 84/20 102/13	essential [3] 63/8 90/10 177/20	essentially [8] 16/23 31/11 35/2 46/5 52/2 87/6 87/10 184/6	excuse [2] 68/11 69/5
email [12] 41/13 41/24 42/1 42/15 42/23 44/7 45/16 88/6 88/7 90/22 129/9 171/15	engaged [3] 5/4 21/25 58/15	establish [1] 68/14	established [2] 59/17 155/15	exec [4] 22/6 23/4 35/21 60/3
emails [3] 43/7 127/15 127/18	engagement [8] 54/18 55/4 68/18 102/22 103/21 104/3 110/13 177/22	established [2] 59/17 155/15	establishment [2] 33/12 178/1	execs [7] 3/21 11/25 20/15 26/7 36/15 67/24 110/13
emerge [1] 180/10	engaging [3] 20/15 96/7 102/11	estate [23] 13/3 25/2 60/6 61/3 67/11 69/16 70/13 71/3 71/5 71/10 85/8 116/8 117/7 117/11 117/21 117/22 118/22 119/8 119/17 139/14 139/22 181/2 193/10	everybody [6] 129/3 129/4 129/4 159/9 177/3 202/14	executive [6] 8/13 110/9 120/18 125/14 125/17 125/20
emerged [2] 133/17 158/23	England [22] 26/8 43/2 51/7 58/15 87/17 112/21 112/23 126/23 143/10 146/7 146/12 148/10 148/14 154/16 159/4 166/9 175/8 179/6 199/1 199/6 200/5 200/15	established [2] 59/17 155/15	everyone [8] 18/18 46/21 51/25 61/8 68/9 91/23 116/19 120/9	executives [3] 2/25 8/3 168/11
emergence [2] 153/11 153/19	English [1] 26/23	et [2] 21/16 21/16	everyone's [1] 7/4	exercise [2] 199/4 199/22
emergencies [1] 103/22	enormous [3] 44/20 79/17 145/6	et cetera [2] 21/16 21/16	everything [10] 10/5 14/9 22/17 72/20 95/3 133/7 142/7 160/19 165/15 187/15	exercises [1] 199/5
emergency [27] 5/11 5/22 5/25 6/5 6/7 6/9 6/12 7/17 16/15 124/22 125/1 132/8 133/4 134/21 144/21 144/24 144/24 147/18 150/8 168/1 169/12 170/4 170/14 170/21 175/12 177/21 181/5	enough [15] 13/2 22/25 30/1 38/6 40/2 40/15 45/3 81/25 88/11 91/14 92/4 92/5 134/13 161/25 177/24	ethical [1] 80/19	evidence [61] 1/16 6/9 10/25 11/2 12/6 13/16 16/4 22/5 22/5 26/12 28/12 29/1 31/2 31/6 31/24 53/22 54/16 54/17 60/9 60/21 60/23 64/10 70/3 70/21 72/13 82/12 85/10 96/2 96/5 96/14 107/5 107/14 107/19 107/22 107/23 108/15 108/23 109/7 109/19 109/22 112/23 113/16 113/22 114/4 115/19 117/14 118/24 119/3 121/15 122/7 128/3 129/12 146/18 148/6 157/20 158/13 158/23 185/12 194/21 197/15 197/19	exhausted [1] 25/23
emergency [27] 5/11 5/22 5/25 6/5 6/7 6/9 6/12 7/17 16/15 124/22 125/1 132/8 133/4 134/21 144/21 144/24 144/24 147/18 150/8 168/1 169/12 170/4 170/14 170/21 175/12 177/21 181/5	ensure [25] 3/4 11/19 11/21 19/24 21/17 41/24 46/14 50/3 64/20 64/23 76/14 84/3 91/9 102/15 115/9 137/6 140/16 161/14 164/23 165/5 177/5 185/18 188/17 196/13 202/24	ethical [1] 80/19	exhausted [1] 25/23	exhaustive [1] 66/20
employed [2] 131/5 176/24	ensuring [6] 31/12 103/1 120/4 125/22 134/8 149/6	ethic [1] 21/16 21/16	exactly [6] 19/3 38/18 39/4 138/6 149/6 189/25	exist [4] 30/17 74/24 125/14 161/12
employer [2] 4/9 95/14	enter [1] 132/25	ethnic [16] 74/16 77/18 78/9 99/4 99/18 100/10 100/19 101/7 102/11 102/14 103/9 103/21 176/12 176/25 177/12 177/25	existed [2] 136/4 161/12	existed [2] 136/4 161/12
employers [4] 56/8 57/1 95/8 95/11	entering [3] 19/6 192/3 192/14	ethnicity [17] 45/24 74/13 75/1 75/8 76/2 76/13 77/15 77/23 78/3 99/9 99/12 100/4 100/24 101/8 101/9 101/12 101/20	exists [3] 77/1 125/14 166/15	existing [9] 49/15 88/14 100/17 136/3 156/14 159/22 159/24 175/9 194/23
employing [1] 78/15	entire [1] 146/6	ethnicity-based [2]	expansion [1] 155/19	expansion [1] 155/19
employment [3] 55/19 56/14 95/5			expect [7] 30/18 50/18 66/10 98/4 98/10 165/9 166/1	expectation [1] 62/11
employment			expectations [1] 168/11	expectations [1] 168/11
construct [1] 95/5			expected [10] 5/3 18/17 20/6 28/6 37/12 43/12 43/13 113/23 128/17 150/22	expected [10] 5/3 18/17 20/6 28/6 37/12 43/12 43/13 113/23 128/17 150/22
empower [1] 182/3				
empowered [1] 182/5				

E	F	fearful [2] 34/24 72/20	137/5 203/5	124/5 124/5 124/8
expedition [1] 16/16	face [16] 31/18 43/18	fears [1] 103/6	finally [8] 45/22	134/7 136/13 136/19
expenditure [1] 118/9	47/8 75/2 160/14	feature [2] 8/1 60/14	71/15 76/6 95/19	136/20 144/19 168/8
experience [11]	160/14 161/2 161/2	February [12] 67/14	171/3 178/24 189/22	175/22
30/12 32/11 54/12	161/7 161/7 161/15	68/4 68/13 78/7 88/18	195/18	focused [7] 51/10
54/16 85/13 98/8	161/15 162/2 162/2	89/23 89/24 106/15	finance [3] 35/20	123/20 136/24 136/25
100/25 103/20 110/15	162/7 162/7	146/21 162/15 173/4	85/7 181/15	140/24 180/22 204/7
119/22 125/4	faced [3] 96/23	175/2	financial [5] 2/21	forcing [1] 124/17
experiences [3] 75/4	116/20 146/23	February 2021 [1]	36/2 125/25 148/15	fold [1] 18/22
96/23 187/1	facilities [3] 49/25	67/14	149/2	follow [9] 7/7 17/24
experiencing [1]	119/16 145/20	fed [2] 56/1 201/2	find [4] 7/5 132/21	41/23 49/2 114/6
187/3	facing [3] 3/17 124/3	Federation [1] 99/4	139/3 184/19	139/2 165/9 166/2
expert [5] 108/1	147/8	feed [3] 186/22 201/6	finding [1] 157/23	200/12
193/3 193/3 194/15	fact [42] 8/3 16/23	201/8	findings [1] 100/12	follow-up [1] 200/12
197/24	20/8 26/19 33/2 37/24	feedback [2] 73/20	finds [1] 74/24	followed [6] 63/25
expertise [2] 121/8	39/23 39/24 41/25	159/22	fine [2] 57/25 72/21	163/7 164/14 165/2
126/16	47/12 58/18 60/7	feeding [1] 187/7	finish [1] 122/7	165/13 165/22
experts [9] 9/10 9/11	60/15 61/4 61/8 62/23	feel [16] 3/15 42/13	first [47] 1/4 1/18	following [11] 7/6
10/19 107/13 142/14	63/12 67/2 67/4 69/2	43/4 65/17 73/21 74/6	9/24 10/5 13/18 13/18	38/20 58/13 89/22
148/4 194/17 194/21	69/17 71/25 72/6 76/2	77/14 79/16 79/24	23/2 26/15 26/20 32/9	99/10 136/7 163/13
198/6	77/24 84/14 100/5	104/8 126/14 126/15	32/12 32/22 42/21	165/25 178/7 189/10
explain [8] 58/13	113/18 113/25 115/11	143/24 160/9 171/18	45/1 57/13 78/9 86/9	194/16
68/11 82/12 124/12	116/5 120/17 136/22	187/10	87/23 88/25 97/22	follows [2] 28/16
141/13 145/14 148/7	139/2 141/24 144/8	feeling [6] 5/4 73/11	104/3 122/13 123/2	185/10
164/15	151/11 156/22 162/23	79/10 86/18 133/23	124/1 127/14 135/2	Fong [4] 109/22
explained [8] 100/23	173/11 196/23 197/12	134/19	135/4 139/4 143/1	110/2 199/1 200/4
124/21 126/8 139/5	factor [8] 67/11 76/2	feelings [1] 79/8	143/7 143/14 148/11	food [2] 73/22 180/25
155/13 155/17 162/23	93/19 94/2 100/5	felt [10] 4/8 5/1 72/18	156/19 157/7 157/15	footprint [1] 119/21
202/15	101/20 104/19 111/11	73/19 79/5 83/25 94/9	169/22 172/8 172/10	fora [2] 4/5 73/14
explaining [1] 86/12	factors [7] 93/5	128/1 155/25 159/24	172/25 172/25 173/9	forced [1] 93/18
explanation [3] 69/4	93/14 93/24 94/14	FEMHO [1] 99/4	176/12 182/14 185/10	forget [3] 11/19
150/20 151/2	99/8 103/10 195/24	few [8] 26/22 71/24	187/21 190/21 203/11	134/17 174/2
explicitly [1] 184/1	fail [1] 88/14	88/11 92/14 144/6	firstly [2] 97/25	forgive [2] 7/8 150/19
explored [1] 171/2	failure [3] 90/11	150/14 191/25 192/1	198/22	form [5] 100/14
exposed [1] 174/17	115/13 199/11	few minutes [1]	fit [15] 38/10 45/23	113/8 166/8 166/13
exposure [1] 152/1	fair [9] 29/4 52/25	71/24	45/23 45/25 46/3 46/7	166/14
expressed [1] 87/16	53/10 62/20 82/21	fewer [2] 19/7 172/3	46/10 46/15 46/16	formal [2] 187/6
extant [1] 164/24	91/15 105/24 168/19	FFP [5] 34/5 35/14	46/16 46/21 47/8	187/9
extended [2] 72/8	195/24	45/22 46/15 47/7	47/15 88/15 181/1	formalised [2] 2/7
72/15	fair to [1] 62/20	FFP masks [1]	fits [1] 18/7	97/14
extending [1] 154/9	fairly [4] 26/6 62/22	45/22	fitted [1] 43/18	formality [1] 66/9
extension [1] 168/23	65/18 148/3	field [20] 24/17 31/10	five [1] 1/19	formally [1] 59/21
extent [3] 142/16	faith [1] 102/25	31/12 31/20 31/22	five years [1] 1/19	formed [1] 8/13
150/10 200/25	fallen [1] 58/21	32/2 32/11 32/20	fix [1] 103/24	former [1] 166/6
extra [11] 23/22	familiar [2] 16/18	32/23 33/2 33/6 33/8	flag [2] 197/22	forms [2] 165/14
29/10 32/2 37/24	128/14	33/16 81/17 132/11	197/25	167/1
44/11 73/1 101/24	families [15] 81/14	132/12 145/19 145/23	flagging [1] 183/18	formulate [1] 124/16
152/1 153/16 173/11	86/4 86/5 92/13	145/24 146/1	flex [5] 21/7 22/3	forth [1] 128/9
173/24	108/13 108/20 136/9	fields [2] 75/9 76/4	22/8 111/17 145/16	Forum [3] 72/17
extract [1] 116/10	141/13 165/18 187/22	figure [6] 23/23	flexibility [4] 141/25	86/16 97/1
extraordinarily [1]	187/24 188/2 188/13	52/11 79/16 111/19	142/10 144/9 185/14	forward [5] 72/11
8/16	190/20 198/16	111/24 197/21	flexible [1] 144/5	90/19 97/24 100/15
extraordinary [6]	family [3] 80/24 94/7	figures [8] 24/2 40/4	flexing [1] 28/24	179/11
5/16 5/18 15/21 16/2	186/25	40/5 59/9 63/9 78/14	flick [1] 76/25	found [8] 37/23 64/17
17/17 104/1	far [7] 58/21 59/4	114/9 174/12	flight [1] 90/11	133/14 149/11 159/12
extremely [8] 95/24	60/10 112/12 114/2	fill [2] 165/14 167/1	flow [11] 5/10 65/8	162/6 181/9 198/16
96/11 151/25 153/13	136/20 172/10	filling [1] 175/6	65/9 112/25 113/4	four [6] 87/18 91/5
155/1 155/9 188/8	faster [1] 34/19	filters [4] 70/16	113/5 113/13 116/4	91/13 134/8 183/3
197/21	favour [1] 83/9	194/20 203/19 203/23	128/4 173/23 173/25	198/20
eye [1] 38/10	fawr [4] 121/11	filtration [3] 193/2	flu [3] 37/22 37/23	framework [42] 10/3
	121/21 204/1 204/11	194/18 195/6	170/7	16/5 16/12 16/22 17/4
	fear [4] 3/12 8/17	final [7] 83/17 85/1	focus [17] 13/12	17/17 18/3 18/11 20/3
	56/13 82/6	88/4 91/4 102/10	16/16 38/16 54/25	20/19 21/21 23/22
			61/14 62/2 63/15	49/2 49/5 49/8 49/8

F	71/6 82/11 84/25 100/16 103/22 104/18 113/7 150/3 178/25 179/11	G	G	G	71/6 82/11 84/25 100/16 103/22 104/18 113/7 150/3 178/25 179/11		
framework... [26] 50/6 50/22 54/25 55/11 68/1 69/21 69/23 70/2 70/9 105/13 125/24 136/6 137/4 137/6 137/18 137/22 139/20 165/11 165/14 165/20 166/3 166/21 188/23 189/4 189/5 189/8	gain [3] 3/18 55/24 175/16	gallery [1] 7/1	gap [1] 175/6	gaps [2] 76/22 202/16	gathering [1] 178/20		
frameworks [6] 9/23 9/24 10/4 10/16 11/24 12/3	gathered [1] 104/14	gave [20] 4/22 13/16 18/3 26/12 51/15 53/13 55/1 86/14 89/9 108/15 108/23 109/22 110/4 129/12 142/10 150/12 173/11 182/4 193/14 197/19	gears [1] 104/14	gelled [1] 44/1 44/18 44/19	gave [20] 4/22 13/16 18/3 26/12 51/15 53/13 55/1 86/14 89/9 108/15 108/23 109/22 110/4 129/12 142/10 150/12 173/11 182/4 193/14 197/19		
Frank [2] 6/10 26/4	general [21] 10/13 23/4 27/9 38/22 71/12 71/14 80/11 81/5 100/11 119/4 124/2 124/20 126/12 130/9 130/18 151/21 152/6 171/11 172/3 179/1 201/2	Frank Atherton [1] 6/10	generally [4] 75/10 92/15 143/20 194/1	gets [2] 12/5 28/14	Frank Atherton [1] 6/10		
frankly [3] 40/20 77/1 91/14	generic [1] 159/25	free [2] 14/4 20/21	genuine [1] 97/6	getting [28] 4/8 9/25 10/23 17/21 28/1 28/18 30/2 32/16 36/25 40/15 50/12 62/13 73/20 78/1 89/18 90/11 108/18 112/9 114/12 131/18 132/4 133/20 141/19 173/12 180/19 186/12 186/23 194/15	frankly [3] 40/20 77/1 91/14		
frequent [1] 140/3	geographically [1] 52/8	frequently [2] 26/16 178/4	George [1] 164/6	given [57] 9/20 10/20 11/17 11/22 19/25 24/22 29/11 33/10 33/11 37/24 45/15 49/18 49/18 54/9 56/7 60/17 61/10 62/7 69/9 69/23 71/1 87/7 88/16 91/10 100/12 107/14 108/20 109/25 115/10 116/14 117/14 130/21 131/15 132/1 132/11 132/13 139/25 145/19 150/20 151/16 151/17 152/19 154/3 154/8 158/22 163/1 166/15 175/6 180/7 182/19 191/23 193/19 194/21 195/7 197/13 197/16 203/10	free [2] 14/4 20/21		
friends [1] 160/3	get [80] 4/13 5/3 8/16 10/10 11/9 14/1 15/1 15/10 17/12 19/5 20/11 21/13 21/17 23/20 24/25 26/2 30/5 30/6 33/5 35/5 36/15 36/20 37/11 39/11 42/23 43/6 44/13 45/2 46/1 50/16 50/20 54/13 55/23 58/23 60/15 61/1 68/24 73/6 79/23 80/22 81/24 89/17 91/1 91/24 94/6 95/1 104/13 112/4 113/12 120/11 120/11 120/12 122/8 123/13 124/7 126/20 127/1 127/3 133/2 133/12 133/15 133/22 138/5 138/15 160/9 160/13 161/7 168/25 173/4 173/20 173/23 180/3 180/6 180/19 180/20 181/5 183/14 191/11 196/20 200/9	front [23] 1/14 5/20 30/16 30/20 31/25 36/25 37/10 59/5 62/5 74/20 127/2 127/3 127/4 133/5 133/24 134/18 160/21 169/1 177/21 182/2 189/24 199/17 202/20	goggles [1] 43/17	going [88] 1/16 2/2 9/9 15/13 17/19 17/22 18/13 19/24 20/4 21/11 21/13 21/16 21/17 22/21 22/25 23/21 31/3 32/11 32/12 33/7 38/18 39/13 40/13 48/6 48/6 52/13 52/21 53/8 55/3 56/20 56/23 61/21 63/15 65/2 73/5 73/5 74/7 74/11 75/6 75/23 83/13 83/22 85/21 86/6 90/19 92/25 92/25 93/4 93/10 93/13 100/15 101/25 104/18 107/24 108/14 110/18 112/13 113/6 116/7 121/7 127/5 133/9 134/5 134/22 140/1 141/17 145/2 145/8 149/7 149/9 149/19 149/21 150/2 152/11 160/22 161/7 173/10 174/1 177/2 179/13 180/20 181/1 181/14 186/1 200/22 201/15 202/14 203/5	frontline [10] 30/12 35/10 36/16 79/1 132/22 169/11 176/3 177/16 182/3 186/23	gold [1] 158/16	FRSM [1] 34/6
fruit [1] 23/1	gowns [4] 36/20 39/24 39/25 40/17	frustrated [3] 87/22 87/24 160/9	gone [2] 44/9 68/24	frustration [1] 87/16	GP [11] 14/7 159/8 159/9 160/14 160/20 160/20 160/25 161/8 161/10 161/15 181/20		
Fu [1] 201/4	good [24] 1/4 1/13 20/7 60/7 61/1 61/14 62/23 63/7 70/23 73/5 77/12 83/8 85/25 92/11 96/20 99/1 108/12 120/11 123/16 139/19 182/17 187/21 190/1 190/18	fulfil [1] 170/25	Goodall [21] 2/18 3/21 19/21 21/22 22/22 23/3 24/9 26/3 30/13 31/17 32/25	Fu [1] 201/4	granted [2] 172/18 172/21		
fulfilled [1] 89/9	Goodall [21] 2/18 3/21 19/21 21/22 22/22 23/3 24/9 26/3 30/13 31/17 32/25	fulfilling [1] 11/21	grades [3] 35/19 36/4 38/14	fulfilling [1] 11/21	grading [1] 43/13		
full [7] 24/23 24/25 113/16 115/8 122/11 130/9 172/21	grange [2] 118/4 119/5	fuller [1] 69/18	granted [2] 172/18 172/21	fuller [1] 69/18	granted [2] 172/18 172/21		
function [1] 16/1	granted [2] 172/18 172/21	funded [1] 32/15	granted [2] 172/18 172/21	function [1] 16/1	granted [2] 172/18 172/21		
funding [7] 31/12 70/15 124/19 155/18 155/22 169/8 169/10	granted [2] 172/18 172/21	funds [1] 118/19	granted [2] 172/18 172/21	funding [7] 31/12 70/15 124/19 155/18 155/22 169/8 169/10	granted [2] 172/18 172/21		
further [11] 55/2 65/2 76/23 77/13 158/9 163/3 172/13 182/12 190/10 190/13 192/25	granted [2] 172/18 172/21	further [11] 55/2 65/2 76/23 77/13 158/9 163/3 172/13 182/12 190/10 190/13 192/25	granted [2] 172/18 172/21	further [11] 55/2 65/2 76/23 77/13 158/9 163/3 172/13 182/12 190/10 190/13 192/25	granted [2] 172/18 172/21		
furthermore [1] 158/19	granted [2] 172/18 172/21	furthermore [1] 158/19	granted [2] 172/18 172/21	furthermore [1] 158/19	granted [2] 172/18 172/21		
future [15] 12/17 62/21 63/3 69/1 71/4	granted [2] 172/18 172/21	future [15] 12/17 62/21 63/3 69/1 71/4	granted [2] 172/18 172/21	future [15] 12/17 62/21 63/3 69/1 71/4	granted [2] 172/18 172/21		

G	H	harmful [1] 14/16	87/25 91/22 96/7 97/2	7/10 24/12 57/24
graph [2] 130/13 134/5	had [291]	harms [1] 82/13	97/18 97/23 98/19	57/25 86/1 99/2 99/3
grateful [5] 105/7 121/16 182/21 197/11	had agreed [1] 118/9	harrowing [1] 134/22	98/19 99/11 99/12	132/22 134/22
198/10	had examples [1] 24/7	has [47] 7/21 14/17	99/21 99/23 99/24	heard [20] 2/18 28/11
great [4] 3/11 34/18 36/1 68/5	hadn't [8] 34/8 37/10 53/1 59/2 87/22 139/3	24/6 25/16 40/16	99/24 100/2 100/13	43/23 115/19 118/24
greater [9] 10/10 14/4 19/19 42/16	158/18 175/2	48/24 54/9 56/14	101/18 102/2 102/14	124/20 124/25 128/8
69/15 69/19 125/7	hairbands [1] 43/18	59/13 63/18 68/24	103/22 104/4 104/11	130/25 134/7 148/4
152/7 186/4	half [6] 39/7 39/7 45/1 81/18 135/7	70/3 75/1 76/9 82/9	105/16 108/5 110/3	158/11 163/22 165/8
green [2] 12/9 12/11	172/3	88/5 94/22 94/25	110/12 114/8 114/23	166/6 178/11 178/25
ground [10] 109/6 109/24 110/5 110/6	hallmark [1] 28/13	105/8 107/1 111/17	115/6 115/24 117/8	182/23 186/14 200/7
110/16 132/22 132/23	hand [6] 8/4 44/1 44/15 44/18 44/19	113/16 117/14 119/17	117/17 117/18 118/5	hearing [4] 4/8 96/10
158/5 200/6 200/10	129/22	124/20 127/24 128/8	120/2 120/5 122/14	97/10 204/15
group [43] 46/21 47/16 59/17 59/18	handover [2] 128/4 167/20	129/4 134/7 136/9	122/18 123/2 123/6	heartbreaking [2] 30/15 30/24
59/20 59/21 59/24	Hannett [8] 104/25 105/5 108/9 197/7	148/4 148/6 158/11	123/8 124/2 124/10	heat [1] 47/11
60/2 60/12 61/10 62/2	197/8 198/11 205/12	158/13 163/22 164/13	124/15 124/19 124/22	heavily [1] 126/11
62/9 62/19 63/13	205/22	164/20 166/6 178/11	124/25 125/23 126/1	Hedges [4] 162/16
65/23 67/14 67/23	happen [18] 13/22 14/3 14/11 15/16 17/5	178/25 179/3 179/5	126/13 132/16 135/6	162/18 162/22 163/1
68/18 71/21 74/15	28/5 109/21 112/11	180/8 182/23 194/21	135/11 135/16 135/25	heightened [1] 100/8
80/19 84/9 126/13	136/21 136/25 148/2	197/12 199/10	136/8 136/16 137/7	held [5] 5/8 5/13 40/2
126/21 134/19 138/7	150/7 150/13 159/4	hasn't [1] 17/25	138/4 138/12 139/5	122/23 150/16
162/19 168/23 168/24	166/24 187/9 187/13	have [322]	139/6 142/1 142/6	help [32] 1/10 3/1 6/1
175/13 176/13 177/12	189/2	have had [1] 51/20	145/3 145/5 146/16	10/21 27/4 29/20
178/1 179/2 187/23	happened [18] 3/6 11/17 13/17 14/24	haven't [8] 22/18 28/7 59/5 75/17 160/7	146/18 147/1 147/2	38/20 42/23 44/23
194/5 195/6 196/8	44/22 49/4 71/20	179/18 201/12 203/15	147/22 148/20 149/8	48/17 48/20 53/15
196/18 201/5 201/10	109/16 142/5 163/9	having [37] 10/2 13/2 22/22 27/10 47/15	151/11 155/4 155/5	54/21 57/7 60/12 61/2
203/2 203/4	163/11 166/5 169/2	48/13 51/16 51/17	155/14 156/9 157/4	70/25 73/20 106/9
groups [19] 73/13 75/4 77/19 78/9 80/4	178/2 181/18 190/7	53/25 65/21 66/7	157/10 157/13 158/20	116/1 117/1 121/20
81/1 84/19 95/14	199/5 199/25	66/13 70/6 73/23 74/2	161/14 163/15 163/20	125/3 128/24 141/13
99/18 100/10 100/19	happening [38] 2/8 4/3 16/21 17/13 23/6	81/17 82/19 82/23	164/23 168/11 175/18	152/20 163/20 173/24
101/18 101/23 103/1	24/5 30/19 37/3 42/5	85/4 87/12 89/4 93/11	175/18 175/21 175/24	184/12 188/16 199/20
105/7 106/14 112/8	59/25 62/3 62/8 67/6	98/8 106/1 119/10	177/6 178/11 179/1	204/10
196/7 197/10	67/25 76/20 89/14	125/4 131/5 143/22	179/7 184/18 185/8	helped [3] 41/4 101/23 117/5
growing [2] 34/21 90/23	98/13 98/18 109/24	145/7 145/24 150/6	185/24 190/4 190/8	helpful [11] 12/22 55/21 77/21 79/3
guarantee [1] 121/18	114/3 127/3 132/21	154/19 166/20 167/24	199/9 200/21 201/4	130/20 160/1 173/16
guard [1] 79/12	137/15 143/2 148/9	171/10 176/20 196/16	201/6 201/8 203/21	179/19 181/3 189/14
guess [5] 93/4 134/12 174/16 177/18	149/13 149/14 149/25	he [18] 1/5 1/6 2/20 7/22 7/24 8/2 8/3	20/16 201/8 203/21	189/20
179/19	152/13 163/13 173/22	23/25 30/21 36/1	60/17 61/12 61/15	helping [1] 121/17
guidance [30] 35/4 80/18 80/18 81/4	179/15 185/22 185/23	70/21 129/12 151/24	61/18 62/24 69/10	helps [3] 16/10 61/3 118/6
102/17 141/7 141/20	192/5 192/21 200/5	160/22 163/5 166/11	78/13 78/14 78/19	HEPA [4] 70/16 194/20 203/19 203/23
141/25 143/4 143/6	200/10	171/16 187/18	78/25 84/4 85/3 99/5	her [10] 41/8 48/15 49/6 74/1 74/2 74/4
143/8 143/12 143/13	happens [5] 55/18 61/23 62/9 62/11	he'd [1] 35/25	100/14 100/18 100/22	85/3 85/6 109/1
143/14 144/8 148/11	65/17	head [2] 124/7 146/24	102/14 102/17 106/1	182/24
148/13 152/20 163/14	happy [2] 151/5 200/14	headline [1] 79/16	112/16 114/12 117/3	her Ladyship [2] 85/3 85/6
164/24 165/1 165/9	hard [4] 14/10 89/4 95/17 103/11	heads [1] 46/4	117/13 120/2 124/13	her Ladyship's [1] 41/8
165/25 183/21 184/1	hardwired [1] 194/24	health [160] 1/20 1/22 2/15 3/13 3/24	124/18 125/2 125/8	here [16] 12/23 27/7 27/9 29/18 39/3 108/6
185/12 185/13 186/15	harm [13] 14/4 14/4 15/13 15/14 25/7	10/14 11/12 12/7	125/19 126/10 132/22	109/16 130/21 131/15
187/2 203/22	67/11 69/3 69/20 73/8	13/25 15/19 16/24	140/3 140/6 141/6	132/10 164/25 165/24
guidelines [1] 105/22	77/19 82/5 136/9	17/6 17/10 17/13	174/9 175/19 177/22	170/2 173/17 180/6
guiding [2] 8/4 95/20	170/19	17/19 21/2 22/6 24/22	177/25 178/12 178/15	186/18
Gwent [1] 18/6	harm's [1] 85/17	25/2 25/25 27/23	178/18 178/21 179/5	high [13] 19/6 114/15 116/23 128/2 131/1
Gwynedd [1] 18/6		32/18 35/25 36/15	179/8 187/4 192/3	136/22 145/15 159/13
		40/3 40/7 45/20 50/8	192/14 192/25 194/6	164/10 167/20 174/15
		54/15 55/25 56/25	194/7 199/13	195/22 202/13
		59/2 60/2 60/10 61/4	healthcare [64] 13/18 18/18 19/12	higher [14] 9/7 67/16
		61/13 64/2 64/17 66/3	45/18 46/8 53/18	
		66/17 67/3 68/21	55/14 55/22 56/4	
		70/19 75/1 75/10	56/15 58/2 58/8 60/15	
		76/13 78/17 78/18	60/17 61/12 61/15	
		80/20 83/23 84/1	61/18 62/24 69/10	
			78/13 78/14 78/19	
			78/25 84/4 85/3 99/5	
			100/14 100/18 100/22	
			102/14 102/17 106/1	
			112/16 114/12 117/3	
			117/13 120/2 124/13	
			124/18 125/2 125/8	
			125/19 126/10 132/22	
			140/3 140/6 141/6	
			174/9 175/19 177/22	
			177/25 178/12 178/15	
			178/18 178/21 179/5	
			179/8 187/4 192/3	
			192/14 192/25 194/6	
			194/7 199/13	
			healthcare-acquired [3] 61/12 61/18 117/3	
			Healthier [3] 49/19 52/6 159/2	
			hear [11] 2/25 7/3	

H	141/3 142/16 167/21 195/3 199/24	94/9 95/11 96/7 96/15 98/4 99/23 101/10 101/21 102/5 103/20 104/7 106/7 106/8 107/9 109/14 109/18 110/2 111/5 111/6 111/15 115/19 116/25 117/15 119/25 120/15 120/15 120/19 122/6 123/9 126/24 128/13 128/14 128/15 129/17 130/4 130/8 130/12 130/14 130/15 130/20 131/6 131/17 132/20 132/22 133/2 133/23 134/18 134/23 136/20 149/18 149/21 149/22 153/3 153/5 153/24 154/17 163/4 165/14 169/3 173/23 174/24 178/15 179/16 185/17 186/5 186/9 190/25 191/13 195/15 198/6 201/9 203/12	I assume [3] 127/22 140/7 189/19 I became [2] 5/12 177/1 I call [1] 122/3 I can [12] 6/23 7/11 32/16 57/25 78/22 86/2 92/17 99/3 149/18 155/24 160/8 168/20 I can't [22] 19/3 28/4 34/13 48/13 51/15 52/12 59/9 64/25 66/1 67/21 70/18 74/3 78/16 87/9 121/18 131/18 132/4 163/6 163/6 177/2 202/5 203/25 I can't say [1] 187/13 I certainly [2] 81/4 136/19 I changed [1] 111/15 I cleared [1] 70/18 I could [6] 114/11 114/19 133/10 186/11 200/8 200/9 I couldn't [2] 52/21 78/5 I covered [1] 38/9 I decided [1] 87/9 I definitely [2] 49/6 184/10 I developed [1] 126/19 I did [9] 30/24 42/14 43/6 64/25 70/18 133/14 149/9 150/20 156/19 I didn't [5] 27/7 41/7 42/2 44/13 128/15 I discussed [2] 79/11 140/18 I do [8] 6/4 48/13 65/1 70/19 148/22 150/16 183/22 195/6 I don't [20] 6/13 10/11 33/16 37/1 47/11 52/3 54/13 69/13 89/10 91/16 106/10 109/19 138/15 156/24 161/20 169/2 177/9 184/15 186/18 200/2 I even [1] 134/1 I eventually [1] 40/5 I expect [1] 50/18 I expected [2] 128/17 150/22 I explain [1] 58/13 I feel [1] 171/18 I felt [1] 155/25 I first [1] 124/1 I follow [1] 17/24 I found [3] 133/14	149/11 181/9 I gave [5] 4/22 13/16 53/13 55/1 173/11 I go [4] 76/10 76/19 104/5 119/2 I got [5] 42/14 45/7 47/5 133/8 153/22 I guess [5] 93/4 134/12 174/16 177/18 179/19 I had [26] 3/21 3/22 3/22 5/12 6/3 32/25 35/16 40/4 46/18 46/22 48/21 54/24 56/17 60/1 66/1 69/13 73/19 73/25 80/3 81/22 90/4 91/1 118/3 124/1 143/16 184/9 I have [11] 6/22 23/3 24/24 43/8 45/7 71/24 75/24 86/20 111/4 182/12 195/16 I haven't [3] 28/7 59/5 201/12 I hear [1] 24/12 I hope [2] 1/14 29/17 I initiated [1] 149/20 I just [5] 31/8 35/13 37/19 184/23 193/16 I knew [6] 27/11 30/25 32/22 128/17 139/13 174/13 I know [21] 5/16 9/25 17/7 25/16 30/21 38/16 47/14 50/14 54/8 66/3 68/25 70/21 78/21 80/1 81/1 101/14 107/4 122/6 163/9 163/17 172/24 I learnt [1] 79/13 I leave [1] 47/18 I looked [1] 40/4 I made [3] 3/5 89/13 121/10 I may [4] 96/22 102/10 105/12 175/15 I mean [2] 147/4 179/15 I mentioned [3] 101/17 188/20 200/19 I met [4] 6/15 96/12 112/8 174/11 I must [1] 80/5 I need [2] 37/2 45/8 I never [1] 109/11 I noticed [1] 126/6 I personally [1] 149/24 I placed [1] 79/17 I point [2] 99/14 113/1 I probably [1] 166/24 I promise [2] 121/19 122/7
higher... [12] 75/2 75/11 77/19 78/1 100/10 140/1 171/20 174/8 177/13 196/25 202/15 203/8 highest [6] 24/15 63/25 79/6 101/19 176/17 196/14 highlight [1] 101/6 highlighted [1] 97/8 highlights [1] 198/2 highly [1] 49/20 him [5] 6/23 7/1 24/2 24/9 163/3 himself [1] 30/22 hinders [1] 61/3 hindsight [5] 72/24 81/16 82/14 143/19 182/24 hips [1] 9/11 his [6] 6/10 26/4 108/24 129/12 160/22 171/15 historic [1] 196/9 hit [6] 8/1 17/25 131/9 131/22 140/20 158/5 hm [1] 157/6 hold [2] 2/10 147/24 holding [1] 126/2 holiday [1] 94/7 home [8] 7/6 43/19 51/11 94/3 95/21 115/23 134/4 195/12 home-made [1] 43/19 homes [2] 63/15 65/4 honest [1] 23/8 honestly [1] 28/4 hook [1] 43/18 hope [2] 1/14 29/17 hoped [2] 150/2 160/8 hopefully [1] 105/9 hoping [2] 180/6 199/20 Horizon [1] 156/9 hospital [50] 11/1 14/21 17/25 19/18 21/8 21/9 24/18 25/2 25/22 26/14 27/1 27/25 28/17 31/20 31/22 33/2 33/6 33/9 33/16 41/14 41/16 41/22 59/15 64/7 67/11 69/16 70/1 70/13 71/12 71/14 88/6 116/13 116/15 118/4 119/3 119/4 119/5 119/9 119/19 119/23 127/13 127/15 137/8 138/3 140/17	141/3 142/16 167/21 195/3 199/24 hospital-acquired [3] 59/15 116/15 137/8 hospitalised [1] 131/24 hospitals [59] 19/8 24/18 24/18 31/10 31/12 32/2 32/11 32/21 32/24 33/8 63/14 63/16 63/22 64/4 65/4 65/5 69/18 69/22 70/1 71/17 127/6 130/9 132/11 132/12 132/21 132/25 133/2 133/16 133/19 135/1 135/14 135/19 136/18 136/23 137/11 137/12 138/16 138/22 139/8 142/19 143/20 145/20 145/23 145/24 146/1 147/19 150/10 173/20 183/4 184/6 191/19 198/23 200/5 200/23 201/11 202/8 203/14 203/18 203/24 host [1] 83/15 hours [1] 174/20 house [1] 44/19 households [2] 83/5 93/3 how [177] 3/3 3/18 9/18 10/10 11/11 12/25 13/3 13/4 13/7 13/22 14/10 16/24 17/22 19/24 20/25 21/7 21/13 21/16 22/20 22/24 23/12 23/20 24/22 26/1 27/9 27/19 27/20 27/21 27/23 29/9 32/17 32/20 33/25 35/4 35/5 37/4 38/14 40/13 40/14 42/12 42/12 42/18 42/23 46/21 48/16 48/16 48/20 49/19 50/3 50/16 51/22 52/7 52/10 54/7 54/10 54/21 56/14 57/6 58/21 59/11 59/15 61/1 61/2 61/2 61/13 61/20 62/20 62/21 64/3 64/4 66/8 66/10 68/1 68/24 71/20 72/24 72/25 73/2 73/11 73/12 73/13 73/19 73/20 76/23 79/1 79/23 80/22 81/24 82/3 82/11 82/11 82/12 84/11 84/12 84/24 85/3 85/11 85/13 85/17 88/13 88/13 89/10 90/13 91/2 91/9	94/9 95/11 96/7 96/15 98/4 99/23 101/10 101/21 102/5 103/20 104/7 106/7 106/8 107/9 109/14 109/18 110/2 111/5 111/6 111/15 115/19 116/25 117/15 119/25 120/15 120/15 120/19 122/6 123/9 126/24 128/13 128/14 128/15 129/17 130/4 130/8 130/12 130/14 130/15 130/20 131/6 131/17 132/20 132/22 133/2 133/23 134/18 134/23 136/20 149/18 149/21 149/22 153/3 153/5 153/24 154/17 163/4 165/14 169/3 173/23 174/24 178/15 179/16 185/17 186/5 186/9 190/25 191/13 195/15 198/6 201/9 203/12 hub [2] 149/10 181/10 hubs [5] 145/21 147/20 149/7 150/11 150/15 hug [1] 74/3 huge [10] 19/11 124/6 129/7 137/17 141/17 144/20 148/17 166/20 173/22 193/24 human [3] 65/18 73/3 84/18 hundred [2] 184/20 184/21 Hutt [1] 73/15		
I	I act [1] 186/19 I actually [2] 74/4 85/9 I always [1] 69/14 I am [5] 67/22 72/1 108/14 136/23 160/20 I appear [1] 105/6 I approved [1] 118/12 I ask [36] 2/23 6/19 8/7 9/5 11/18 12/17 13/10 13/13 15/18 16/22 21/11 24/13 29/11 31/14 32/20 34/4 47/20 50/23 51/12 58/2 58/7 59/13 63/11 66/6 74/12 74/12 85/20 92/12 141/11 143/4 146/16 147/1 187/21 190/19 197/9 198/15 I asked [3] 128/15 149/21 174/14	I		

I	74/11 78/19 78/20 87/24 89/14 89/18 97/23 113/22 114/4 120/23 123/10 123/12 123/14 123/16 123/19 126/2 128/12 128/23 130/23 132/5 132/6 132/25 133/15 155/4 155/24 156/3 156/4 157/17 160/20 160/21 163/9 163/9 169/1 173/22 174/12 174/23 176/4 177/9 184/17 184/20 184/20 192/11 195/7	I'll give [2] 94/6 102/23 I'll just [1] 188/5 I'll move [1] 202/6 I'll never [1] 134/17 I'll skip [1] 102/10 I'm [62] 2/2 9/1 10/23 10/24 22/4 24/6 25/7 26/3 28/11 28/23 45/21 52/22 54/9 58/25 63/1 63/15 66/13 67/25 68/16 69/3 77/8 86/3 86/6 93/13 99/4 100/1 103/17 104/4 105/24 107/24 108/1 112/13 116/7 121/16 148/23 150/19 151/5 158/9 162/9 162/9 163/6 168/19 175/5 178/4 179/21 180/6 189/12 189/12 189/24 193/3 193/3 197/24 198/10 199/19 199/24 200/1 200/22 201/14 201/15 202/10 202/21 203/5	123/21 135/3 140/4 identifying [1] 97/19 ie [2] 182/25 183/6 if [189] 5/5 7/5 7/6 7/8 8/19 10/21 10/24 11/6 11/15 14/12 14/12 14/19 14/20 14/24 15/1 15/8 15/22 16/6 16/10 17/10 18/6 19/12 19/19 20/3 20/8 21/2 21/11 21/13 21/17 22/14 22/25 23/16 24/8 26/8 27/17 27/24 28/16 29/1 30/2 32/16 33/15 35/10 35/10 37/12 37/13 39/4 40/9 47/23 48/2 48/18 52/1 53/11 54/1 54/23 56/4 56/13 58/25 61/20 62/24 63/5 64/1 64/19 66/13 67/20 68/6 70/18 70/18 71/9 72/10 72/20 72/22 74/7 74/8 74/22 75/16 77/2 77/19 78/6 78/17 78/17 80/9 81/22 82/5 82/20 83/2 83/5 83/7 85/2 85/8 87/9 88/2 92/17 92/23 93/9 95/17 96/14 96/22 97/18 100/1 100/2 100/7 100/9 100/24 101/13 102/10 104/2 104/3 104/4 104/5 104/5 104/19 105/11 109/15 110/1 113/1 113/5 114/19 119/2 120/7 121/9 123/1 124/9 127/1 127/17 129/9 131/18 133/6 133/11 135/9 139/22 139/23 141/1 142/23 143/16 144/11 145/17 146/13 147/16 147/17 148/23 149/17 150/7 150/21 151/7 152/5 152/16 154/3 157/17 158/7 159/10 160/2 160/9 160/11 162/9 162/12 163/6 163/13 163/25 166/12 166/14 167/1 167/8 168/19 168/22 170/16 171/4 171/15 172/20 174/25 175/2 175/5 175/15 177/8 177/19 177/20 181/22 182/8 184/9 185/16 189/20 194/25 196/12 196/19 196/23 199/25 200/3 201/23 202/10 202/19	immediate [3] 76/12 76/16 183/20 immediately [1] 168/3 immunosuppressed [2] 154/6 154/13 impact [22] 4/20 13/24 15/17 30/9 56/8 59/14 69/7 74/16 78/8 78/20 99/18 100/18 101/6 114/22 118/21 140/13 146/19 155/2 172/25 174/18 175/17 178/19 impacted [2] 67/23 142/17 impacts [2] 51/5 97/4 impairments [1] 82/2 implement [3] 118/22 141/19 192/17 implementation [3] 120/4 185/11 187/2 implemented [5] 137/4 139/3 148/24 185/17 192/1 implementing [1] 141/21 importance [6] 53/20 69/1 72/2 101/7 109/20 184/1 important [18] 4/14 27/21 29/8 34/11 65/11 70/4 84/23 109/10 109/17 114/14 114/18 117/3 123/11 138/24 141/6 141/21 187/25 188/8 importantly [1] 148/14 imposed [1] 80/9 improve [13] 71/2 75/18 75/25 76/12 76/24 84/21 85/3 85/8 103/21 116/24 117/10 119/14 119/22 improved [2] 68/16 119/18 improvement [1] 68/7 improvements [2] 101/12 118/2 improving [3] 77/4 99/24 118/9 inability [1] 116/10 inadequacy [1] 39/14 inadequate [5] 37/11 38/2 40/21 40/23 45/19 inappropriate [4] 80/8 109/12 162/14 199/5 inaudible [4] 13/1 60/25 62/1 93/23 inaudible-cough [1]
I put [1] 190/10 I recall [4] 65/21 71/18 112/12 114/2 I received [2] 53/12 106/12 I rely [1] 198/6 I remember [7] 17/20 56/18 130/10 130/13 144/2 191/3 196/16 I represent [5] 108/20 182/17 188/1 196/8 202/7 I said [5] 20/5 77/5 168/23 178/1 195/15 I saw [4] 24/9 78/14 114/9 169/1 I say [6] 56/16 119/20 184/10 192/6 192/19 204/5 I set [2] 32/6 76/18 I shall [2] 57/17 121/23 I should [2] 17/3 79/10 I spent [1] 39/17 I spoke [3] 55/5 61/17 127/8 I start [3] 1/17 16/5 72/4 I still [1] 56/11 I suddenly [1] 91/1 I suggested [1] 167/3 I suppose [1] 62/6 I suspect [1] 24/11 I then [2] 42/3 42/17 I think [246] I thought [3] 14/9 73/4 168/20 I took [6] 32/22 43/10 44/10 94/7 150/22 184/8 I tried [2] 40/9 200/8 I trust [1] 104/4 I turn [1] 58/1 I understand [8] 14/25 14/25 22/22 24/20 29/1 38/5 52/7 61/4 I understood [2] 60/19 84/16 I used [3] 107/25 132/25 133/1 I valued [1] 79/21 I visited [3] 150/14 156/22 176/3 I want [6] 35/12 42/7 42/10 92/14 190/20 195/18 I wanted [3] 22/20 36/11 105/11 I was [48] 7/18 13/25 23/13 38/18 50/9	I wasn't [2] 107/3 128/13 I wish [2] 116/4 118/18 I won't [4] 87/9 115/8 190/10 190/13 I wonder [1] 167/8 I worked [2] 46/22 90/5 I would [8] 30/18 31/17 32/4 98/10 104/18 113/23 143/12 143/16 I wouldn't [3] 28/10 65/14 110/19 I wrote [1] 151/6 I'd [29] 5/13 24/2 34/13 37/17 43/7 44/6 52/22 79/11 79/19 89/13 96/15 96/22 99/22 113/23 126/18 128/11 133/3 135/7 136/23 150/2 160/9 162/12 163/7 164/1 168/19 175/20 182/21 190/4 190/8 I'd always [1] 79/19 I'd be [3] 34/13 52/22 96/15 I'd been [1] 135/7 I'd held [1] 5/13 I'd just [1] 175/20 I'd like [7] 37/17 96/22 136/23 162/12 163/7 164/1 182/21 I'd manage [1] 133/3 I'd only [1] 168/19 I'd seen [2] 44/6 89/13 I'd stopped [2] 190/4 190/8 I'd want [1] 99/22 I'll [9] 94/6 102/10 102/23 134/17 188/5 189/13 191/11 200/14 202/6 I'll be [1] 200/14 I'll come [1] 189/13 I'll get [1] 191/11	I've [14] 35/6 44/18 72/13 85/10 87/16 90/3 106/5 152/23 189/6 189/24 194/4 195/8 195/15 198/20 I've been [1] 90/3 I've covered [1] 85/10 I've ever [1] 195/8 I've expressed [1] 87/16 I've got [2] 189/24 198/20 I've just [1] 189/6 I've mentioned [1] 194/4 I've never [1] 106/5 I've no [1] 195/15 I've outlined [1] 152/23 I've said [1] 35/6 I've set [1] 72/13 iawn [1] 121/21 IC [1] 200/24 icecream [1] 94/8 ICNet [3] 200/24 201/13 202/2 ICU [4] 14/7 18/25 21/12 26/15 idea [3] 130/24 195/15 195/16 ideal [2] 166/24 177/3 identified [8] 123/24 138/19 188/4 188/7 188/9 188/10 189/8 202/1 identify [4] 123/9	123/21 135/3 140/4 ill [1] 83/2 illness [1] 29/24	

I	indicate [3] 88/12 89/14 191/1	162/16 172/17	institution [1] 35/13	introduced [5] 99/11 99/15 143/17 181/8 183/9
inaudible-cough... [1] 62/1	indicated [4] 17/7 25/16 135/17 193/12	informing [1] 162/18	instrumental [1] 156/13	introducing [1] 119/1
inaudible-coughing [1] 93/23	indicates [2] 135/12 170/3	infrastructure [5] 21/8 65/6 113/10 116/8 120/18	insufficient [4] 7/23 8/8 109/1 116/17	invasive [2] 14/14 31/5
incentives [2] 148/15 149/2	indicating [1] 64/3	initial [3] 36/10 39/12 136/11	intended [1] 151/24	invent [1] 28/10
incentivise [1] 148/20	indication [3] 15/3 15/5 108/17	initiate [1] 200/12	intense [1] 133/25	inventing [1] 52/22
incidence [1] 177/13	individual [25] 4/18 30/9 42/20 55/19 77/22 78/6 80/23 93/22 112/7 119/5 136/14 137/7 137/13 137/25 138/1 139/16 139/24 154/23 165/2 180/3 185/20 186/18 193/14 199/23 203/17	initiated [1] 149/20	intensity [2] 133/25 184/22	invest [6] 75/20 99/24 113/7 117/22 117/22 193/10
incident [3] 90/8 137/9 188/14	individually [1] 40/10	inordinate [1] 184/17	intensive [9] 14/12 15/2 25/14 28/14 29/2 30/6 32/2 131/1 173/2	investigate [7] 71/16 114/7 136/1 163/4 164/21 199/4 199/23
incidents [4] 136/7 163/4 164/12 164/16	individuals [1] 13/23	INQ000214235 [1] 38/21	interaction [1] 79/21	investigated [3] 137/13 137/25 195/4
include [6] 2/5 12/18 150/3 166/13 170/6 188/15	ineffective [1] 168/16	INQ000227599 [1] 74/19	interest [6] 32/22 34/9 44/11 89/21 91/2 151/6	investigating [1] 137/7
included [10] 6/8 16/14 18/11 24/17 97/12 101/8 127/16 132/16 159/21 188/23	inequalities [11] 74/23 74/24 99/12 100/18 104/11 104/12 104/13 146/16 177/24 180/15 180/19	INQ000299062 [1] 41/12	interested [7] 21/6 42/14 54/10 65/15 91/1 96/15 102/5	investigation [4] 71/19 105/21 137/10 146/19
includes [2] 86/4 187/23	inequality [2] 100/13 147/2	INQ000327640 [1] 201/15	interesting [2] 159/2 200/17	investigations [7] 71/16 105/17 136/4 137/23 138/1 138/2 198/22
including [24] 2/15 3/25 4/1 6/11 15/10 19/15 40/23 43/7 45/3 45/12 98/13 99/9 102/3 107/10 115/6 118/25 125/23 125/24 126/22 165/16 166/10 175/18 196/11 200/20	inevitable [1] 30/25	INQ000349686 [1] 114/19	interim [4] 137/5 167/24 188/4 190/11	investing [1] 113/10
incomplete [1] 37/21	inevitably [4] 9/8 28/12 28/14 62/9	INQ000396261 [1] 63/11	International [2] 122/22 156/9	investment [3] 19/16 146/22 181/3
inconsistencies [1] 141/9	inexpensive [2] 192/17 193/21	INQ000413883 [1] 188/6	interrupt [1] 41/7	investments [1] 117/12
inconsistency [2] 10/9 157/12	infamous [1] 90/8	INQ000474242 [1] 16/9	intervened [1] 98/19	involved [3] 149/24 165/18 195/25
inconsistent [1] 188/10	infected [2] 64/6 196/25	INQ000474252 [2] 1/15 50/25	intervention [5] 43/11 53/17 72/25 106/4 107/6	involvement [1] 156/12
inconsistently [1] 189/9	infection [23] 43/21 59/16 60/8 60/20 61/12 61/18 67/17 69/24 81/15 99/9 116/15 117/4 117/4 119/6 134/25 135/3 138/16 140/2 143/23 152/1 193/11 196/10 199/24	INQ000480061 [1] 170/1	interventions [2] 56/7 99/11	IPC [18] 61/1 61/14 62/23 63/7 64/20 68/15 68/21 69/1 70/17 118/22 119/14 119/18 119/22 120/5 121/5 134/25 140/16 142/14
inconvenienced [1] 51/25	infectious [5] 60/18 60/18 63/5 70/8 104/15	INQ000480092 [1] 164/9	into [73] 4/13 4/17 7/22 14/17 14/20 15/13 21/11 25/7 28/25 29/17 32/12 33/4 37/11 37/14 39/13 44/9 44/12 47/16 49/5 52/3 52/13 54/13 67/18 69/10 70/1 73/7 75/6 83/1 83/13 93/2 93/25 104/5 111/25 114/7 114/14 114/16 114/22 123/2 127/5 132/21 133/4 133/15 137/10 138/1 138/2 142/16 144/13 144/14 146/19 147/7 147/10 147/11 151/10 155/10 158/1 159/10 160/22 169/6 169/19 173/2 175/23 175/25 179/4 181/1 185/19 186/13 186/22 187/15 188/20 198/22 199/4 200/4 201/2	Irish [1] 198/24
increase [10] 9/9 18/22 20/1 23/20 70/15 79/7 93/1 146/22 153/7 170/4	influenced [1] 158/4	INQ000499523 [1] 29/14	interruption [1] 41/7	irrespective [1] 183/11
increased [7] 43/20 63/18 68/3 83/7 115/21 142/23 145/11	inform [1] 101/10	inquiry [44] 1/9 5/22 9/11 24/6 29/13 29/16 37/20 43/16 53/23 54/17 105/8 107/12 109/22 113/17 114/22 122/10 124/20 127/18 128/8 134/7 148/4 148/7 148/10 158/11 158/15 163/22 166/6 166/11 178/11 178/17 178/25 179/19 179/24 180/1 182/23 189/21 190/23 194/19 194/21 197/12 199/20 200/15 205/5 205/16	interven [1] 98/19	is [360]
increasing [5] 63/17 105/18 124/23 147/16 193/2	information [25] 26/2 54/22 55/24 69/7 95/23 102/16 110/14 116/9 116/22 126/14 126/16 127/12 131/4 131/15 131/18 132/4 132/12 133/20 142/14 178/14 178/17 178/18 196/4 199/17 201/12	Inquiry's [1] 107/13	insert [1] 107/24	isn't [26] 11/9 13/22 26/8 27/14 36/24 49/9 52/1 62/14 76/4 86/18 87/14 90/25 98/14 101/1 104/19 110/15 114/3 116/25 119/25 124/25 130/1 131/4 137/2 183/16 183/23 197/21
incredible [2] 182/7 202/21	informed [3] 25/25	Inspectorate [2] 163/15 163/21	insofar [1] 64/22	isolate [2] 139/24 155/8
incredibly [1] 68/13		install [1] 70/20	Inspection [1] 107/24	isolated [1] 164/12
indeed [16] 3/13 7/11 7/14 7/14 16/21 64/1 84/19 86/2 89/6 95/8 121/14 129/7 131/4 131/11 151/18 155/3		installed [1] 119/13	instance [4] 80/13 109/12 144/5 163/10	isolation [4] 154/21 173/25 200/21 203/17
independent [2] 145/20 175/7		instances [3] 95/16 143/3 144/6	instead [2] 51/9 197/14	issue [35] 2/19 4/16 4/23 4/24 5/7 6/14 17/4 31/10 35/7 39/17 42/12 42/20 46/20 46/20 70/6 80/17 81/5
INDEX [1] 204/17				

I	84/23 87/15 90/4 90/23 93/5 94/1 94/1 94/1 103/19 103/25 104/25 107/1 107/5 107/22 108/2 108/10 109/10 110/7 110/19 111/13 112/3 114/20 114/24 117/15 119/20 121/14 124/6 125/17 127/4 127/14 128/11 131/1 137/2 138/5 138/24 139/16 146/12 146/13 147/10 148/1 151/8 153/8 153/23 158/6 162/15 167/17 168/19 170/1 170/17 171/10 172/12 173/17 173/18 179/22 179/24 180/16 181/6 181/6 182/5 183/9 183/16 183/23 188/1 192/4 192/19 200/24 201/2 201/16	43/23 Jones [6] 26/4 108/23 185/2 185/4 187/17 205/18 journey [1] 105/25 Judith [4] 22/5 54/9 107/5 179/2 Judith Paget [3] 54/9 107/5 179/2 Judith Paget's [1] 22/5 July [11] 72/7 72/10 83/20 86/13 86/22 92/18 113/19 114/24 151/20 158/5 168/5 July 2021 [1] 113/19 June [11] 72/6 74/21 127/20 127/23 129/15 135/4 135/18 155/18 155/23 158/4 167/23 junior [1] 105/2 just [127] 4/11 4/18 7/3 7/15 13/22 16/21 16/23 17/21 19/17 24/7 28/20 31/8 35/13 35/17 36/2 37/1 37/19 38/10 39/5 40/24 42/2 42/9 42/14 42/19 44/8 44/9 46/19 46/23 49/3 52/15 57/5 61/20 63/14 63/15 65/7 66/23 69/24 72/2 73/23 74/22 76/4 76/20 77/6 80/15 80/16 85/7 86/23 87/14 87/21 87/22 90/20 90/22 90/25 91/19 91/22 93/14 94/6 94/14 95/19 101/4 102/19 103/5 104/7 104/17 106/16 109/2 110/15 111/19 112/7 114/20 121/7 127/10 129/23 130/7 130/11 130/18 130/21 133/1 140/19 142/6 143/20 145/3 146/1 146/13 147/23 147/23 149/5 152/9 152/14 153/4 153/5 157/23 158/3 163/8 165/11 165/17 169/1 171/13 172/8 173/17 175/3 175/20 177/9 178/8 181/8 181/25 182/7 184/16 184/23 187/18 187/25 188/5 189/6 189/24 190/4 190/24 191/10 191/12 192/11 193/16 195/12 195/13 197/15 197/19 197/20 200/6 200/18 just the [1] 66/23 Justice [4] 86/4	108/13 187/22 198/16 justification [1] 197/1 justified [1] 93/9	K KC [10] 85/24 98/25 105/5 187/19 197/8 205/7 205/11 205/12 205/20 205/22 keel [1] 45/5 keen [4] 52/22 94/6 163/17 179/21 keep [8] 57/9 82/3 118/1 145/7 152/2 157/21 157/23 181/11 keeping [4] 157/25 159/1 167/6 185/22 kept [4] 67/2 178/13 186/9 186/11 Keshav [1] 102/21 key [6] 123/19 141/18 180/9 188/11 189/25 194/3 Khaw [1] 201/4 kicking [1] 126/23 kind [20] 29/21 30/12 126/23 127/6 128/22 132/2 132/15 141/24 144/5 153/4 163/17 165/24 173/4 176/6 181/6 185/23 186/10 194/22 203/16 203/16 kinds [4] 96/2 139/10 180/23 180/25 Kingdom [3] 166/22 180/5 199/25 Kloer [8] 10/25 12/6 17/7 25/13 26/12 30/20 113/17 114/5 Kloer's [1] 70/21 knew [22] 9/9 27/11 29/20 30/25 32/22 60/18 62/7 65/4 67/3 77/19 100/5 123/22 128/17 139/13 139/21 140/21 149/6 155/5 159/9 165/12 165/14 174/13 knocked [1] 144/24 know [157] 2/13 3/11 4/6 5/16 9/25 12/13 12/14 14/15 15/15 17/7 18/7 21/12 22/4 22/24 24/21 25/4 25/16 29/6 30/20 30/21 30/21 30/24 33/14 36/11 37/3 37/15 37/22 38/16 39/21 40/19 42/7 44/18 46/8 46/25 47/14 47/24 48/19 50/8 50/14 54/8 55/13 58/21 59/6 61/20	61/24 61/24 66/3 66/11 66/20 68/25 70/19 70/21 72/4 73/4 74/2 74/14 78/21 79/17 80/1 81/1 89/8 96/10 96/14 100/22 101/14 101/16 107/4 115/16 117/20 118/15 122/6 128/10 129/5 130/6 130/8 130/20 131/10 131/20 132/16 133/11 134/3 135/4 140/6 140/21 142/2 145/2 147/5 147/12 147/23 149/8 149/12 149/24 150/9 150/11 150/14 150/16 152/11 152/11 154/16 156/24 157/18 158/5 158/6 160/3 160/6 160/8 160/18 160/25 161/1 161/21 161/23 163/9 163/17 167/1 167/3 167/4 169/2 172/24 173/19 174/21 174/25 176/3 177/9 177/19 178/15 179/22 180/1 180/24 181/1 181/2 181/21 181/23 181/23 182/8 184/8 184/18 184/20 184/21 184/22 184/23 185/25 186/13 192/5 192/6 192/18 194/13 194/14 195/6 195/10 195/14 200/2 200/7 200/14 200/16 202/12 202/12 203/14 knowing [2] 130/7 192/25 knowledge [3] 3/16 50/2 107/18 known [3] 47/21 48/24 168/9
issue... [18] 91/3 135/5 145/23 146/16 164/25 165/11 173/6 173/10 173/17 174/2 174/14 174/21 178/9 183/18 191/3 194/2 198/1 199/5 issue and [1] 173/10 issue directions [1] 2/19 issue for [1] 35/7 issue had [1] 135/5 issue here [2] 164/25 173/17 issue in [1] 178/9 issue of [3] 31/10 146/16 199/5 issue over [1] 174/14 issue that [1] 4/16 issue throughout [1] 70/6 issue was [1] 165/11 issue with [2] 81/5 145/23 issued [10] 9/23 9/24 10/2 10/3 11/24 12/2 34/14 40/7 81/3 162/19 issues [28] 4/2 4/7 4/10 4/11 4/13 4/14 43/14 45/22 46/7 58/24 59/3 88/20 120/19 123/14 157/24 161/11 162/4 163/16 167/17 168/14 175/15 177/14 187/3 189/23 200/19 200/21 201/7 201/14 issuing [2] 17/17 203/22 it [476] it directive [1] 18/3 it's [136] 5/17 6/4 12/22 13/14 14/10 15/5 15/5 22/4 23/12 23/17 25/2 26/9 27/20 27/21 29/8 31/9 36/24 38/13 41/13 43/9 48/19 49/25 50/6 50/25 51/20 52/7 52/15 52/25 53/3 53/18 55/9 55/16 56/15 56/19 58/16 61/8 61/19 61/19 62/1 62/14 62/20 64/9 65/10 65/16 65/16 65/18 66/8 68/2 69/4 72/2 73/8 73/24 74/20 75/16 75/23 76/1 76/5 76/25 77/6 78/4 79/23 79/25 81/18 82/10 82/18 83/1 83/1 83/10	Italy [4] 13/17 14/5 88/17 89/2 item [1] 35/3 items [5] 40/18 44/19 44/24 46/12 89/15 iterations [1] 65/2 its [11] 27/12 49/13 50/11 68/18 72/2 114/23 170/4 176/17 176/18 188/4 199/8 its March 2023 [1] 188/4 itself [10] 14/16 17/17 21/23 52/6 87/15 93/1 93/14 186/16 198/18 199/11	J Jane [1] 73/15 Jane Hutt [1] 73/15 January [6] 105/14 113/16 114/16 117/8 157/7 159/18 January 2022 [1] 159/18 Jean [3] 118/25 182/24 183/8 Jean White [2] 182/24 183/8 Jean Wright [1] 118/25 Jenny [1] 11/3 Jessica [1] 185/2 job [5] 56/17 128/12 161/23 168/25 203/2 jobs [1] 94/5 John [1] 175/11 John's [1] 185/6 joint [2] 37/5 37/5 Jonathan [1] 43/23 Jonathan Rees [1]	L laboratory [2] 113/8 116/12 labour [1] 104/6 labs [1] 115/19 lack [13] 11/19 64/14 65/13 74/25 75/7 77/14 87/13 88/8 88/8 88/19 170/25 173/6 184/13 Lady [17] 1/4 1/12 6/21 6/22 57/18 57/23 98/22 104/22 105/1 108/7 121/12 121/21 122/3 197/11 197/18 198/10 204/2 Ladyship [2] 85/3 85/6 Ladyship's [1] 41/8 LAMP [2] 112/23		

L			
LAMP... [1] 113/8	least [10] 12/20 25/3	lifting [2] 141/15	159/7
landed [1] 90/9	39/1 48/11 61/11 72/6	152/5	lived [1] 71/1
lanes [1] 12/9	104/19 146/25 150/4	light [7] 74/25 107/19	lives [9] 13/12 14/23
Language [2] 122/18	151/13	151/20 153/10 154/5	15/11 78/19 78/24
122/23	leave [4] 19/18 47/18	172/4 199/10	83/19 108/22 172/6
large [7] 3/9 13/8	86/17 129/4	Lighthouse [1]	178/16
15/9 78/21 112/25	led [8] 35/14 42/18	115/19	living [4] 3/12 15/15
114/10 146/24	43/21 49/24 87/13	like [43] 4/14 14/7	54/20 107/10
largely [1] 57/10	120/4 138/22 203/8	19/4 21/2 26/8 28/23	Llais [1] 187/5
larger [2] 53/2 69/17	left [4] 33/18 47/6	32/16 33/3 37/17	local [35] 2/15 8/17
largest [1] 25/3	88/11 202/20	39/10 41/25 42/23	10/10 16/24 25/25
last [8] 38/1 38/25	legally [1] 95/6	44/2 44/13 47/9 48/7	37/6 40/8 43/25 49/14
63/19 89/3 89/5	length [2] 2/2 26/8	71/6 71/6 72/25 75/11	53/14 64/16 91/24
103/19 116/7 183/3	lengthy [1] 167/20	77/5 92/18 95/18 96/3	91/25 121/3 121/7
lasted [1] 39/7	less [6] 28/2 79/9	96/22 100/7 113/23	121/7 121/8 124/14
late [3] 69/23 83/4	79/16 100/9 152/13	119/15 120/19 136/23	136/16 137/7 141/6
113/18	154/7	137/20 143/12 147/18	141/8 142/2 148/20
later [15] 1/19 17/8	lessened [1] 195/2	153/4 162/12 163/7	157/4 157/10 157/12
20/5 22/2 25/7 58/5	lesson [2] 83/15	164/1 165/25 173/18	158/19 176/23 177/6
60/22 77/1 126/2	182/2	182/21 186/19 191/2	178/11 185/14 185/18
131/21 132/7 164/6	lessons [18] 9/1 9/3	193/2	186/3 186/6
172/8 175/25 183/25	12/22 136/21 137/17	liked [2] 126/18	localised [2] 36/11
lateral [7] 65/8 65/9	138/13 138/18 138/24	186/22	37/7
112/25 113/4 113/5	139/1 143/1 178/24	likelihood [1] 78/1	locally [5] 40/9 49/22
113/12 116/4	179/7 179/10 179/12	likely [12] 9/3 18/14	50/17 141/25 144/9
latter [1] 125/4	180/9 180/9 199/19	28/1 29/24 31/18	locate [1] 114/20
launched [1] 188/24	199/21	47/21 48/9 69/10	lockdown [2] 44/9
Lauren [1] 108/24	let [4] 53/6 56/19	140/2 152/13 153/7	44/9
law [1] 156/4	101/4 103/19	171/19	locked [2] 83/18
lawyer [3] 1/18 56/17	let's [1] 195/14	limit [1] 121/19	96/24
107/25	letter [11] 94/23	limited [3] 25/24	long [75] 21/9 47/20
lay [1] 32/17	94/24 96/6 99/16	26/17 124/17	47/22 47/24 48/9
layout [2] 19/17	151/5 153/12 154/1	limiting [2] 64/22	48/11 48/12 48/18
119/21	164/17 165/7 193/8	111/11	48/25 48/25 50/11
lead [11] 1/9 6/5 34/3	196/2	limits [2] 24/15 64/11	50/13 50/16 52/11
42/16 45/14 48/23	letting [1] 185/24	line [19] 30/16 30/20	52/15 52/19 53/9 54/1
55/5 68/21 91/6 98/12	level [32] 18/13 19/1	36/25 37/10 41/21	54/5 54/20 54/23
205/4	28/15 29/4 36/2 36/7	51/12 62/15 80/15	54/25 55/1 55/15 56/5
leaders [4] 2/10	36/23 49/14 50/3 76/3	127/2 127/3 127/4	57/9 61/10 61/25 89/5
66/25 102/15 112/8	83/7 91/24 98/1	133/5 133/24 134/18	105/7 105/12 105/15
leadership [2] 68/19	108/21 117/24 120/18	160/21 164/24 177/21	105/23 106/17 106/18
121/7	128/1 128/6 128/10	182/2 202/21	106/18 106/20 107/8
leading [1] 98/17	128/17 128/24 129/1	liners [1] 36/19	107/11 107/13 107/15
leads [2] 99/15 149/4	129/3 129/5 129/8	lines [5] 5/20 39/20	107/17 118/20 123/15
leaning [1] 61/25	130/7 130/8 130/25	89/6 91/19 91/25	128/3 129/6 133/3
learn [17] 9/1 12/22	130/25 176/21 198/18	link [2] 1/5 117/2	146/14 149/21 155/12
34/7 34/12 36/4 49/9	203/24	linked [4] 10/12	155/17 156/8 156/13
54/7 54/10 84/23	level 4 [3] 128/6	99/12 116/13 148/15	156/17 156/18 157/14
96/15 103/18 128/13	128/10 129/8	list [7] 11/8 151/16	157/16 157/17 158/2
136/21 180/5 199/14	level 5 [1] 129/3	151/18 151/19 152/24	158/12 158/16 158/20
199/19 199/20	levels [10] 45/10	153/15 154/12	158/22 159/23 160/6
learned [7] 138/13	61/17 79/7 128/3	listen [6] 54/16 85/12	161/1 167/2 173/20
178/24 179/8 179/10	128/8 128/14 129/8	85/18 98/5 103/17	181/22 184/8 184/8
179/12 180/9 201/3	131/3 133/16 136/22	133/4	197/10 197/20 197/22
learning [16] 13/6	liberated [2] 72/19	listened [2] 5/5 84/12	198/3
48/5 69/1 78/8 82/10	73/12	listening [1] 106/22	Long Covid [53]
83/14 84/6 107/6	liberating [1] 83/19	lists [8] 9/7 34/1	47/20 48/11 48/18
109/20 143/1 157/16	life [7] 9/14 11/16	145/15 146/8 146/24	48/25 50/11 50/13
188/4 188/11 189/16	77/9 81/21 168/4	147/8 149/22 149/23	50/16 52/11 52/15
189/25 190/3	170/22 171/5	little [6] 17/8 64/1	52/19 53/9 54/5 54/20
learnt [4] 79/13	life-changing [1]	106/15 141/2 156/1	54/23 54/25 55/1
137/16 138/25 139/2	11/16	195/13	55/15 56/5 57/9 105/7
	life-threatening [1]	live [6] 11/15 22/18	105/12 105/15 105/23
	168/4	23/18 82/20 82/24	106/17 106/18 106/18

L	make [74] 8/11 13/11 13/22 14/1 18/3 18/7 23/16 28/8 31/9 32/4 32/14 33/22 40/8 40/21 44/24 46/11 53/10 53/14 53/14 60/7 63/5 65/24 79/9 80/18 81/25 82/4 84/11 84/15 85/2 85/11 94/13 97/19 101/21 102/6 103/8 103/12 107/24 108/4 110/18 111/7 111/8 113/7 118/7 118/13 120/15 123/15 136/20 137/16 139/10 141/22 150/23 157/19 161/5 162/3 163/8 163/17 165/12 165/15 166/24 167/2 167/5 168/9 169/13 177/7 177/15 179/14 179/23 179/25 180/21 184/9 187/9 193/24 197/3 200/12	54/6 64/3 64/4 84/7 91/25 92/20 129/6 129/17 130/14 130/16 130/20 144/22 178/15 187/23 196/24 map [2] 104/11 104/12 March [36] 3/6 9/6 16/6 16/13 21/4 34/21 39/6 39/6 41/14 44/9 58/4 60/11 60/22 61/5 62/8 69/21 70/9 72/5 88/6 89/7 90/23 90/24 106/15 113/18 116/11 122/15 129/11 135/12 151/9 170/13 172/19 188/4 193/8 193/16 195/19 203/6 March 2020 [1] 60/11 March 24th [1] 44/9 markedly [2] 120/25 174/7 married [3] 133/22 160/20 160/20 marry [2] 55/18 133/21 mask [3] 35/15 35/19 47/14 masks [14] 34/5 34/6 34/10 38/16 41/20 43/18 43/25 45/22 46/5 46/15 46/21 47/8 88/8 96/3 mass [1] 113/3 match [1] 18/13 materials [1] 44/24 maternity [8] 81/10 81/17 97/2 143/5 143/21 144/1 182/20 184/14 maternity-related [1] 184/14 matter [6] 61/23 62/1 85/19 110/18 112/1 118/18 mattered [3] 45/13 46/10 91/21 matters [8] 65/20 75/22 82/1 85/16 98/5 110/20 186/16 195/20 maximise [1] 23/12 may [58] 1/17 1/19 1/19 1/24 2/24 4/2 6/19 6/24 9/6 23/14 29/3 31/8 41/7 49/1 50/22 51/1 53/6 54/4 56/10 59/17 60/13 61/9 66/6 71/24 72/2 74/12 86/22 96/22 102/9 102/10 105/12 109/5 122/3 122/15 122/19 123/3 135/12 136/15 138/11 138/22 140/15 143/7 144/14	145/16 152/6 154/6 154/7 155/25 156/10 156/15 162/12 173/3 175/15 183/12 183/25 186/6 197/13 204/5 May 2021 [1] 122/15 maybe [2] 57/15 198/2 me [45] 7/10 13/17 13/21 23/25 27/4 35/6 35/7 35/24 37/10 42/19 44/7 47/12 53/6 56/19 57/24 59/5 60/3 60/5 68/3 74/1 74/9 75/15 80/12 85/1 86/1 86/8 94/25 95/10 99/2 100/7 101/4 103/19 104/7 105/2 109/8 109/12 114/2 149/15 150/19 168/22 168/24 169/2 173/5 189/25 202/18 mean [28] 13/13 14/8 14/9 36/12 38/5 40/15 41/7 55/23 93/15 93/17 93/21 103/11 106/3 106/25 111/21 112/10 115/17 120/10 120/11 120/12 120/21 124/6 128/24 134/10 147/4 160/5 179/15 186/18 means [16] 12/15 26/6 53/23 54/11 80/25 83/12 95/1 98/8 103/12 109/11 125/25 129/1 134/13 157/15 175/16 196/19 meant [14] 14/2 19/8 22/9 36/5 69/19 71/13 74/1 77/25 113/9 114/13 128/10 133/10 138/21 142/1 measure [4] 17/18 131/6 134/10 191/25 measured [2] 15/24 204/8 measures [31] 15/22 16/3 16/18 17/9 22/15 31/8 64/20 71/11 82/17 89/23 90/1 90/20 96/6 97/18 101/22 118/20 118/20 118/22 120/5 121/5 134/25 135/1 139/10 140/16 140/22 140/24 141/12 152/16 191/25 192/1 193/1 mechanical [1] 70/24 mechanism [8] 30/11 159/8 191/17 191/21 191/22 191/23 192/12 192/19 mechanisms [2]	125/25 128/9 media [1] 164/11 medical [34] 7/21 12/7 25/15 30/18 30/19 30/23 35/16 54/18 55/8 56/6 59/23 60/3 60/6 62/16 73/17 80/20 83/23 106/3 106/6 110/10 110/10 110/13 126/11 140/18 151/15 151/22 152/22 153/2 153/14 153/22 154/14 195/22 196/5 201/8 medicalising [1] 105/16 medicine [10] 5/22 5/25 6/5 6/7 6/9 6/12 7/18 28/14 110/25 134/21 medics [2] 41/19 147/12 meet [6] 6/2 43/4 116/17 152/2 170/5 170/9 meeting [7] 6/13 66/13 66/15 124/1 168/1 168/3 168/10 meetings [14] 3/17 5/8 5/13 5/24 6/3 6/7 6/10 7/16 11/25 26/25 66/16 106/14 126/1 178/4 member [5] 1/18 100/8 153/9 162/16 164/5 members [8] 4/24 5/1 78/23 135/20 154/24 168/16 196/8 201/19 men [1] 46/6 Meng [1] 201/4 mental [5] 122/18 155/5 175/18 175/21 200/21 mention [2] 140/24 144/12 mentioned [11] 25/21 26/4 26/11 43/14 70/13 101/17 109/25 132/20 188/20 194/4 200/19 message [2] 42/2 72/24 messaging [1] 103/15 met [8] 2/24 6/15 43/7 58/12 94/8 96/12 112/8 174/11 Metcalfe [3] 148/5 148/10 148/17 method [2] 52/5 195/1 methods [1] 125/22
M	MACA [2] 169/21 172/22 made [71] 3/5 8/23 9/15 10/15 16/22 27/4 30/15 30/24 31/2 35/4 43/19 44/17 44/20 45/14 46/5 46/11 48/8 50/9 68/20 74/7 77/20 78/7 79/7 80/7 87/6 87/17 89/13 89/24 96/5 96/13 97/11 109/9 109/13 112/10 112/16 113/13 113/24 114/1 114/25 117/17 118/3 121/10 124/7 126/21 127/13 140/4 141/2 142/4 142/9 143/10 146/15 154/16 155/23 159/8 160/12 160/24 161/25 162/21 165/6 165/13 166/3 171/7 171/8 172/12 172/22 176/14 185/15 186/5 186/23 188/12 195/16 Maelor [1] 121/1 magic [1] 182/9 magical [1] 183/9 main [4] 9/3 14/20 71/8 144/17 mainly [1] 2/20 maintained [1] 72/9 maintenance [2] 117/19 117/20 major [2] 144/22 200/23 majority [1] 68/6	maker [1] 107/25 makes [3] 147/13 173/5 181/1 making [41] 4/9 23/16 30/10 34/13 42/19 43/25 44/15 44/18 44/21 46/2 50/1 61/21 68/16 90/14 101/11 103/4 104/1 109/9 111/6 115/14 115/25 116/23 120/16 120/17 123/17 124/14 137/18 139/18 139/18 150/6 161/15 165/16 180/15 183/18 184/20 191/18 192/7 195/21 201/1 201/2 202/14 manage [13] 20/9 20/23 40/9 40/10 70/20 70/24 72/25 73/13 85/13 106/7 106/8 133/3 198/7 managed [8] 26/9 27/1 27/14 45/2 89/17 90/13 91/19 179/16 management [10] 62/15 105/22 106/17 114/23 149/13 155/17 156/12 156/17 198/4 198/5 managers [1] 133/12 managing [3] 52/2 73/3 136/6 mandate [1] 9/17 mandatory [5] 2/20 18/4 176/22 177/7 184/5 manner [4] 114/8 120/6 204/7 204/8 many [17] 23/15 54/4	140/15 143/7 144/14	

<p>M mid [6] 47/19 57/16 58/18 86/14 92/20 113/18 mid-April [1] 58/18 mid-August [2] 86/14 92/20 mid-March [1] 113/18 mid-morning [2] 47/19 57/16 middle [8] 5/3 77/2 86/10 93/6 153/19 171/16 200/9 202/18 Midwifery [1] 98/18 midwives [1] 98/12 might [25] 9/2 13/1 13/5 14/11 19/5 22/3 30/3 30/6 30/17 66/10 68/10 77/17 77/20 81/16 109/9 113/7 130/12 131/7 144/7 151/6 152/20 153/18 153/20 192/5 202/15 Mike [1] 162/16 Mike Hedges [1] 162/16 mild [1] 48/1 military [3] 169/20 171/19 175/2 million [10] 136/12 136/12 145/4 145/5 155/19 156/2 169/8 169/16 173/11 175/23 mind [6] 47/3 52/11 71/23 75/16 88/1 163/25 minimise [3] 96/8 118/21 152/1 minimum [1] 152/3 minister [69] 1/21 1/24 2/1 5/3 5/13 11/18 15/19 22/23 30/13 34/4 34/8 39/19 42/6 42/10 42/24 46/17 54/21 61/21 71/1 73/16 76/16 77/16 80/7 83/21 84/2 85/15 90/14 91/9 95/10 97/23 107/23 108/3 110/3 110/16 122/13 122/14 122/17 122/22 123/2 123/8 124/10 124/17 124/21 125/4 125/20 127/22 133/7 135/6 139/6 141/4 147/2 151/10 151/12 155/4 155/5 155/14 156/15 161/14 165/5 167/16 175/16 177/2 179/7 184/18 186/10 187/21 190/5 190/8 200/8</p>	<p>minister's [2] 87/25 176/12 ministerial [13] 2/4 52/14 70/18 105/15 105/19 106/16 117/24 125/21 126/9 126/21 167/25 169/7 169/24 ministers [5] 59/19 59/20 59/21 75/18 91/13 minor [2] 4/14 4/16 minorities [1] 103/9 minority [10] 74/16 99/5 101/7 102/11 102/14 103/21 176/12 176/25 177/12 177/25 minute [3] 66/14 66/14 66/20 minutes [2] 66/16 71/24 misconception [1] 198/3 mislead [1] 164/2 Miss [3] 90/3 104/25 187/17 Miss Carey [1] 90/3 missed [1] 194/9 mission [2] 33/5 91/17 mistake [1] 103/8 mistrust [1] 35/1 mitigate [1] 79/9 mitigating [1] 95/25 mitigation [1] 71/3 mitigations [1] 94/17 mixing [1] 153/5 Mm [1] 157/6 Mm-hm [1] 157/6 model [15] 20/19 31/25 33/10 53/13 53/19 54/2 54/14 106/25 107/2 107/2 120/14 120/15 156/7 159/1 159/5 modelling [2] 18/16 21/12 models [3] 10/10 54/8 54/11 modern [1] 203/17 modernised [1] 119/17 module [7] 1/9 13/16 41/8 108/23 198/17 202/1 205/5 Module 2B [1] 13/16 modules [1] 37/21 moment [4] 15/18 18/17 47/18 63/2 Monday [1] 127/25 money [11] 32/16 40/21 85/9 118/1 118/19 119/10 136/19 136/24 158/3 158/4 182/5</p>	<p>monitor [8] 40/2 97/18 140/4 178/21 185/17 192/2 192/13 201/11 monitored [2] 140/7 149/16 monitoring [15] 76/15 78/12 98/1 98/15 98/16 130/11 149/12 149/18 149/20 149/25 186/1 192/9 192/10 194/7 194/7 monitors [11] 190/21 190/24 191/6 191/10 191/12 192/16 192/24 193/10 193/13 193/19 193/23 month [12] 10/18 10/18 10/18 11/20 58/19 128/12 135/7 145/4 156/1 167/24 168/20 168/23 monthly [4] 5/8 149/20 149/25 174/11 months [4] 34/19 42/22 157/4 164/6 months' [1] 34/17 morale [1] 41/17 more [120] 5/18 8/6 8/13 8/21 9/2 9/6 10/13 11/16 12/5 12/12 12/15 14/7 14/7 14/15 14/22 14/23 15/5 15/14 19/9 19/9 19/14 19/14 20/7 20/17 21/1 21/6 24/9 24/11 27/8 28/24 29/24 30/2 33/7 34/5 35/14 37/7 40/22 45/5 46/20 48/3 53/3 54/2 65/7 65/7 66/18 68/4 68/9 69/9 69/10 71/2 76/21 81/16 82/14 82/15 83/12 85/4 85/5 87/8 87/14 87/15 89/17 91/21 93/10 95/23 96/1 100/20 103/25 104/10 106/1 108/3 111/25 114/11 114/12 117/24 117/25 118/1 118/18 126/16 127/4 128/22 131/24 132/1 132/1 133/8 136/20 137/14 137/24 139/17 139/23 139/25 140/13 144/5 147/13 148/13 149/5 149/8 152/10 156/1 156/5 156/6 160/16 169/11 171/19 171/19 172/10 173/2 173/4 173/12 174/16 177/5 178/5 181/5 181/24 184/3 184/5 186/22 191/9</p>	<p>196/7 200/13 203/17 more weeks [1] 20/7 Morgan [16] 122/4 122/5 122/6 122/12 122/13 167/14 182/13 182/17 185/5 190/18 190/21 197/9 197/15 197/19 204/4 205/14 Morgannwg [4] 21/3 21/16 24/25 116/9 morning [13] 1/4 1/13 1/14 47/19 57/16 66/6 88/17 105/3 105/13 106/13 119/25 128/6 183/7 mortality [2] 101/19 165/20 most [8] 24/10 30/15 47/25 49/17 92/21 141/21 180/17 195/7 most days [1] 24/10 mother [5] 73/25 74/8 98/5 98/13 104/7 mothers [3] 98/14 98/15 101/1 mount [1] 145/18 move [15] 8/4 25/13 96/10 101/4 112/13 114/14 134/24 144/11 151/7 160/11 162/12 168/5 168/7 202/6 203/5 moved [5] 25/6 70/8 95/20 176/4 184/3 movement [1] 166/15 moving [4] 7/18 23/15 95/22 142/22 Mr [78] 1/5 1/8 1/10 1/13 6/1 6/22 7/12 8/2 8/7 13/14 16/8 16/10 25/20 26/12 28/1 29/5 29/15 30/13 36/12 38/19 41/7 41/13 42/24 43/23 50/24 51/2 52/7 56/24 57/15 57/24 58/17 64/23 69/12 71/24 73/14 74/20 76/17 80/6 81/11 85/2 85/20 85/23 85/24 85/25 92/8 92/9 92/10 92/11 92/16 93/6 96/17 96/20 97/17 98/21 98/24 99/1 104/21 104/23 105/6 108/8 108/12 121/14 162/18 162/22 163/1 183/6 187/18 187/19 190/14 190/15 190/16 190/17 197/6 205/3 205/7 205/8 205/19 205/21 Mr Atherton [2] 8/2 30/13</p>	<p>Mr Gething [41] 1/13 6/1 6/22 8/7 13/14 16/8 16/10 25/20 28/1 29/5 29/15 36/12 38/19 41/7 41/13 42/24 43/23 50/24 51/2 52/7 56/24 57/15 57/24 58/17 64/23 69/12 71/24 73/14 74/20 76/17 80/6 81/11 85/2 85/20 85/25 92/11 97/17 98/21 104/21 108/8 183/6 Mr Hedges [3] 162/18 162/22 163/1 Mr Kloer [1] 26/12 Mr Thomas [1] 98/24 Mr Vaughan [3] 1/5 1/8 205/3 MR WAGNER [6] 92/10 93/6 190/15 190/17 205/8 205/21 Mr Weatherby [5] 85/23 92/8 92/16 187/18 190/14 MR WEATHERBY KC [2] 85/24 205/7 Ms [36] 1/3 57/22 86/7 86/9 88/4 88/5 96/18 96/19 96/24 104/24 105/5 108/9 108/10 108/11 121/13 122/2 148/5 167/13 182/14 182/16 185/2 185/4 185/11 197/7 197/8 198/11 198/12 198/13 204/3 205/9 205/12 205/13 205/17 205/18 205/22 205/23 Ms Carey [7] 1/3 57/22 86/7 86/9 88/4 88/5 96/24 Ms Chloe Scott [1] 148/5 Ms Hannett [3] 108/9 197/7 198/11 MS HANNETT KC [4] 105/5 197/8 205/12 205/22 Ms Jessica Jones [1] 185/2 MS JONES [2] 185/4 205/18 Ms Nield [2] 122/2 167/13 MS SHEPHERD [3] 108/11 198/12 205/13 Ms Sivakumaran [1] 104/24 Ms Waddoup [5] 96/18 182/14 182/16 185/11 205/17 much [47] 5/6 10/4</p>
--	--	--	---	--

M	my Lady [11] 1/4 1/12 57/18 57/23 98/22 104/22 108/7 122/3 197/11 197/18 198/10 myself [3] 24/9 107/24 155/24	166/25 172/22 173/3 173/4 173/14 180/14 180/14 183/10 needed [43] 4/11 8/4 10/20 15/25 17/12 18/22 20/1 29/2 40/18 47/16 97/16 97/20 108/19 111/22 112/9 123/10 123/12 123/18 126/6 126/15 126/15 129/2 137/20 139/14 141/22 142/11 149/8 152/19 155/25 156/5 157/21 159/4 159/17 161/16 161/19 168/5 168/7 173/15 176/1 176/5 176/7 191/7 194/14 needed it [1] 108/19 needs [7] 50/21 97/6 107/9 139/4 185/20 186/7 200/13 negative [2] 114/18 159/22 neighbouring [1] 25/25 neither [2] 13/20 107/4 neonatal [7] 83/2 83/10 118/9 182/22 183/2 183/5 183/17 Net [1] 200/24 network [11] 21/23 26/24 26/24 27/11 27/14 27/15 31/20 31/21 32/9 32/10 175/25 networks [2] 11/1 30/17 never [14] 10/17 25/13 47/3 80/25 88/1 106/5 109/11 111/10 112/6 112/11 134/14 134/17 180/20 183/14 nevertheless [2] 11/8 27/15 new [24] 47/15 50/13 71/8 71/10 81/22 90/7 119/9 119/19 119/20 119/23 134/24 144/11 147/4 148/1 148/3 156/2 157/17 162/12 173/13 173/15 175/3 181/10 184/18 198/8 news [2] 36/17 44/6 next [13] 3/11 10/18 16/4 33/1 35/2 102/9 104/7 108/10 149/15 180/11 186/17 194/19 203/19 NHS [69] 2/10 2/14 2/24 3/17 8/3 8/12 13/12 13/14 14/1 14/3 14/6 15/3 15/11 23/4	35/21 71/3 76/13 76/20 91/7 91/24 110/9 110/22 115/4 116/8 116/10 116/12 117/7 117/11 118/21 119/4 124/3 124/15 125/9 125/13 125/17 125/20 125/22 127/22 127/24 134/8 134/11 134/15 134/16 139/12 145/11 148/14 155/16 158/25 166/4 175/9 175/15 175/19 175/22 176/9 176/14 178/9 179/3 179/6 180/8 181/2 182/1 186/16 188/3 188/17 189/2 191/8 192/17 193/10 194/15 NHS England [2] 148/14 179/6 NHS Wales [12] 23/4 35/21 71/3 110/9 115/4 117/11 119/4 139/12 179/3 180/8 188/3 194/15 NI [1] 171/22 NICE [1] 105/22 Nield [2] 122/2 167/13 nightmare [1] 15/12 no [46] 3/17 9/17 14/7 14/7 14/7 15/21 20/22 23/8 24/14 28/11 30/8 41/17 53/11 58/13 69/2 70/7 70/7 70/11 82/19 90/22 92/20 93/16 99/14 104/1 110/1 111/2 111/23 116/13 132/5 132/15 134/5 136/15 137/9 153/1 168/23 182/12 186/10 193/12 195/15 195/16 198/22 198/25 199/22 201/14 202/5 203/25 nobody [2] 11/13 114/2 non [22] 9/7 9/10 9/21 10/22 12/4 16/14 16/15 31/5 33/12 45/24 64/15 64/24 65/13 102/4 129/22 129/23 129/24 130/3 130/5 130/17 144/21 169/12 non-clinical [3] 64/15 64/24 65/13 non-Covid [3] 9/21 12/4 33/12 non-Covid-19 [2] 129/22 129/23 non-critical [4] 129/24 130/3 130/5	130/17 non-devolved [1] 102/4 non-emergency [3] 16/15 144/21 169/12 non-invasive [1] 31/5 non-urgent [4] 9/7 9/10 10/22 16/14 none [5] 14/3 14/4 75/14 103/7 180/22 nor [2] 13/21 29/15 normal [8] 8/25 11/14 15/22 23/2 62/15 109/10 111/16 130/19 normally [5] 5/2 42/10 62/12 62/12 117/23 north [3] 17/11 17/11 17/11 north-east [1] 17/11 north-west [1] 17/11 northern [4] 13/17 14/5 89/1 198/24 Northern Ireland [1] 198/24 nosocomial [45] 58/1 59/14 59/16 60/4 60/9 60/14 60/19 60/25 61/7 61/9 62/13 63/6 63/13 65/22 67/14 67/17 67/19 67/23 68/17 69/8 69/13 69/24 71/15 134/25 135/3 135/13 135/24 136/7 136/18 137/3 137/11 138/14 138/16 138/22 139/7 140/14 141/1 142/15 142/18 188/3 188/22 190/3 199/24 202/24 203/3 not [225] note [9] 86/20 99/6 130/14 135/22 136/10 138/24 147/9 166/9 174/5 noted [4] 88/10 146/22 168/2 170/17 notes [1] 140/10 nothing [4] 13/8 19/4 39/10 114/3 notice [1] 162/25 noticed [1] 126/6 notices [3] 162/13 162/14 162/19 notified [1] 164/12 noting [3] 128/11 147/14 153/23 novel [2] 70/11 107/16 November [17] 1/1 63/14 63/17 63/19 67/16 68/13 79/4 112/18 112/19 112/20
----------	---	---	---	--

<p>N</p> <p>November... [7] 135/18 169/7 169/10 169/18 172/13 172/23 204/16</p> <p>November 2020 [1] 67/16</p> <p>now [39] 2/13 7/9 9/14 15/12 15/15 18/10 23/22 26/11 36/21 49/11 52/25 53/25 54/5 67/10 67/21 71/6 77/10 81/11 85/21 94/22 99/3 108/2 112/13 117/19 119/9 125/13 125/13 143/18 147/20 154/2 154/15 159/3 175/15 178/6 180/3 181/10 182/9 194/12 197/19</p> <p>number [59] 1/13 2/14 3/3 16/13 16/17 20/20 25/20 26/19 27/7 35/12 37/17 46/8 48/2 51/8 51/13 51/19 51/21 51/24 52/9 52/19 53/2 53/8 53/25 55/14 55/22 63/23 63/25 66/6 66/21 70/13 71/25 86/3 86/5 88/25 91/21 105/8 112/25 114/25 117/12 129/16 129/22 130/22 131/11 131/19 138/23 140/4 142/5 142/17 145/11 146/5 168/10 172/4 173/3 174/3 178/21 180/8 196/7 198/16 202/7</p> <p>numbers [18] 15/9 19/14 21/5 28/24 34/11 51/16 54/22 69/17 114/10 132/16 132/18 132/24 133/23 137/24 145/15 145/17 171/21 175/1</p> <p>numerical [3] 129/13 132/19 133/21</p> <p>numerically [1] 20/23</p> <p>numerous [1] 124/4</p> <p>nurse [14] 3/23 28/21 59/24 62/17 62/17 65/22 66/13 68/20 79/11 80/2 82/9 98/17 110/11 193/11</p> <p>nurses [5] 26/15 41/17 79/8 80/21 88/9</p> <p>nursing [9] 27/2 29/7 79/4 80/2 98/16 126/12 182/23 193/9 203/6</p> <p>nutshell [1] 16/20</p>	<p>O</p> <p>o'clock [2] 16/12 204/13</p> <p>objective [1] 57/11</p> <p>obliged [1] 136/1</p> <p>observance [1] 54/9</p> <p>observation [2] 9/16 13/11</p> <p>obstacles [1] 144/18</p> <p>obtain [2] 163/3 186/24</p> <p>obvious [6] 28/20 28/22 61/11 103/12 121/15 153/3</p> <p>obviously [23] 9/11 10/16 26/20 32/14 48/19 63/15 72/5 125/24 127/8 127/11 139/16 141/18 141/22 142/10 142/24 144/21 146/10 160/2 171/22 173/1 175/13 177/3 187/7</p> <p>occasion [1] 153/14</p> <p>occasions [3] 81/4 142/5 151/14</p> <p>occupancy [3] 19/7 19/21 24/15</p> <p>occupational [2] 77/24 101/18</p> <p>occupied [11] 64/4 127/16 129/17 129/18 129/18 129/22 129/23 130/3 130/4 130/22 131/19</p> <p>occur [1] 147/15</p> <p>occurred [1] 163/5</p> <p>occurring [2] 64/12 141/14</p> <p>October [11] 2/3 50/22 51/4 52/25 55/1 122/19 122/24 163/23 169/6 170/13 173/3</p> <p>October 2020 [1] 52/25</p> <p>odd [1] 137/14</p> <p>off [11] 14/2 15/24 17/19 20/24 22/10 25/11 79/12 108/14 111/7 150/24 184/22</p> <p>off-guard [1] 79/12</p> <p>offer [4] 94/11 162/1 171/18 172/3</p> <p>offered [1] 196/24</p> <p>offering [1] 157/10</p> <p>offhand [1] 59/9</p> <p>office [7] 8/12 35/17 121/10 144/13 177/19 201/21 201/22</p> <p>officer [21] 7/21 35/17 59/23 73/17 98/17 98/18 110/10 110/10 116/9 116/22</p>	<p>126/11 126/12 140/19 151/15 151/23 152/22 153/2 153/14 153/22 154/14 182/23</p> <p>Officer's [1] 60/6</p> <p>officers [1] 54/19</p> <p>official [1] 195/20</p> <p>officials [10] 6/3 42/4 46/19 46/22 47/5 59/24 90/5 113/24 123/23 154/25</p> <p>often [12] 4/10 8/14 33/15 42/9 42/23 64/13 100/10 106/9 117/19 117/25 133/6 195/10</p> <p>Ogbonna [1] 102/20</p> <p>Ogbonna and [1] 102/20</p> <p>Oh [2] 6/23 104/25</p> <p>okay [3] 43/1 101/4 200/7</p> <p>old [4] 61/24 71/9 139/14 139/22</p> <p>older [5] 80/11 84/17 147/5 162/5 203/14</p> <p>oldest [1] 119/3</p> <p>Omicron [9] 131/9 131/22 140/12 140/20 140/21 153/11 153/19 153/24 154/1</p> <p>on [359]</p> <p>once [9] 28/12 32/14 39/16 77/18 87/25 88/1 101/9 118/3 154/1</p> <p>one [101] 8/10 9/10 13/2 18/7 18/15 18/21 23/9 24/8 27/20 29/11 31/8 32/13 36/18 36/18 38/17 39/6 39/7 39/9 43/15 45/6 46/9 48/22 54/2 55/9 59/15 60/5 60/10 61/16 63/3 64/1 64/17 66/9 68/11 68/25 71/23 73/8 82/20 83/15 85/2 87/14 91/17 93/5 94/1 104/1 104/9 105/24 106/25 107/14 107/20 108/2 108/3 109/2 109/10 109/16 115/14 120/14 126/19 127/17 127/25 129/3 129/5 129/19 138/13 140/24 144/12 149/1 149/9 150/8 150/14 151/3 151/4 152/17 156/19 158/17 161/5 161/8 163/25 165/10 166/12 166/14 179/3 179/21 179/23 183/6 184/10 186/15 186/16 187/25 187/25 190/22 191/5</p>	<p>191/25 191/25 194/18 194/21 195/7 195/20 195/24 197/14 201/19 204/6</p> <p>one-stop [2] 107/14 107/20</p> <p>ones [8] 45/12 57/1 108/21 162/10 162/20 185/9 188/8 188/13</p> <p>ongoing [4] 50/11 69/11 136/17 196/9</p> <p>online [5] 7/7 127/11 161/3 175/4 181/23</p> <p>only [23] 8/20 9/12 15/21 24/1 32/23 33/18 39/7 74/11 82/23 88/11 96/5 110/19 117/4 128/11 129/19 130/21 153/12 155/24 159/15 168/19 175/3 191/17 191/25</p> <p>ONS [1] 52/16</p> <p>onward [1] 55/24</p> <p>open [8] 70/22 70/23 85/12 106/19 139/15 152/12 160/25 199/11</p> <p>opening [1] 193/1</p> <p>openness [1] 136/16</p> <p>operate [4] 11/11 12/25 13/3 145/25</p> <p>operates [2] 61/13 111/6</p> <p>operating [7] 9/23 10/3 11/3 15/7 17/6 68/1 111/18</p> <p>operation [3] 36/1 196/17 196/22</p> <p>operational [11] 2/16 4/6 11/13 26/24 32/17 32/24 120/3 124/13 140/9 186/13 186/16</p> <p>operationally [1] 3/8</p> <p>operations [1] 11/20</p> <p>opportunities [2] 117/23 139/21</p> <p>opportunity [7] 40/23 56/10 142/1 160/19 163/8 189/18 194/10</p> <p>opposed [9] 10/15 18/4 40/14 40/17 51/21 70/10 82/19 103/9 200/6</p> <p>optimal [1] 28/2</p> <p>optional [1] 177/8</p> <p>options [2] 151/17 171/1</p> <p>or [142] 9/17 10/18 11/19 12/19 12/20 15/2 17/3 20/19 20/21 21/18 21/19 23/23 23/23 24/22 26/17 27/6 27/24 28/4 30/4 31/14 32/23 33/12 35/13 37/1 38/6 38/7</p>	<p>40/9 43/4 43/17 45/23 46/9 47/13 53/10 53/17 56/1 56/6 56/16 56/21 57/3 58/25 59/8 59/14 61/3 62/16 63/20 65/4 68/15 68/16 69/7 70/7 70/16 70/18 74/25 75/7 75/9 77/14 77/16 77/25 78/11 78/17 79/9 80/8 80/15 81/19 83/1 83/11 83/11 83/25 84/3 84/14 86/24 87/6 87/8 87/21 89/5 89/25 90/1 92/1 92/2 94/15 94/16 94/19 97/7 97/10 97/15 100/2 100/7 107/8 109/20 112/7 123/22 125/8 125/19 126/15 126/16 130/25 131/1 131/11 133/21 136/8 137/11 138/3 140/4 141/12 142/13 142/13 143/11 145/20 149/16 150/4 150/24 151/17 151/18 154/7 154/25 155/3 159/24 160/4 162/7 162/13 165/1 165/5 166/6 166/17 173/7 177/6 179/3 179/8 180/8 181/22 185/16 185/18 186/8 188/21 192/18 193/1 196/24 199/4 200/24 201/21 202/16 203/22</p> <p>order [4] 18/4 170/5 173/24 179/10</p> <p>ordered [1] 59/1</p> <p>ordinate [1] 125/10</p> <p>organ [1] 198/5</p> <p>organisation [6] 4/20 78/12 125/1 187/5 187/14 187/23</p> <p>organisations [12] 78/15 78/21 96/21 99/5 102/15 120/13 127/9 127/10 182/18 185/7 186/19 186/25</p> <p>organise [2] 3/4 8/20</p> <p>organised [3] 49/18 158/25 197/3</p> <p>organs [1] 48/19</p> <p>original [1] 172/20</p> <p>original September [1] 172/20</p> <p>originally [1] 119/24</p> <p>orthopaedic [8] 41/19 148/4 148/12 149/7 149/10 150/11 150/12 150/14</p> <p>other [63] 2/6 4/1 7/15 14/17 16/17 20/9 22/12 22/14 25/11</p>
--	--	--	---	--

<p>O</p> <p>other... [54] 26/22 27/16 30/23 33/24 38/25 39/21 43/24 44/14 45/3 45/16 47/18 49/22 70/16 72/2 72/7 73/24 74/8 75/18 76/8 77/20 81/18 86/24 87/3 91/20 92/2 103/8 107/15 110/25 111/7 111/17 116/13 122/8 125/8 126/18 130/17 141/12 144/17 147/9 147/14 161/9 165/19 171/1 174/1 174/8 176/19 177/10 181/25 187/3 191/7 192/5 192/20 193/1 198/20 200/19</p> <p>others [9] 12/8 20/6 42/4 59/1 61/17 91/18 118/25 186/20 193/4</p> <p>otherwise [5] 24/22 30/6 33/22 57/13 66/10</p> <p>ought [1] 30/11</p> <p>our [59] 3/13 12/3 14/10 14/24 15/15 19/14 29/9 32/11 34/22 35/7 37/12 39/20 39/21 41/16 42/4 44/12 44/15 47/19 49/18 50/7 51/10 57/16 59/25 65/24 69/16 75/10 75/13 79/17 79/19 82/3 84/10 88/17 90/7 91/12 99/15 99/23 100/21 107/9 109/18 111/5 116/19 118/5 118/15 119/17 120/14 139/15 145/15 148/3 149/1 159/1 165/9 165/9 167/4 181/14 196/1 199/16 199/24 202/12 202/15</p> <p>ours [2] 137/14 200/16</p> <p>out [84] 2/2 6/4 7/5 16/13 24/24 27/3 27/23 32/6 35/10 36/7 37/14 37/25 40/21 44/22 52/5 53/21 58/3 58/16 63/14 63/23 66/22 70/21 72/13 72/21 73/2 75/23 76/18 77/6 79/14 80/20 81/8 83/18 85/7 89/15 94/6 96/24 99/14 113/2 113/15 113/15 113/18 114/8 115/8 115/9 115/11</p>	<p>115/13 124/10 125/12 130/12 130/15 132/21 133/13 134/1 134/14 136/25 138/11 139/3 140/11 141/5 141/20 144/24 147/17 150/7 152/22 156/18 156/21 157/23 160/2 165/14 168/10 169/4 171/16 176/13 186/15 189/2 189/25 190/2 190/4 190/9 196/2 196/4 200/17 202/14 203/7</p> <p>outbreak [4] 71/18 114/23 135/17 202/1</p> <p>outbreaks [16] 61/6 65/3 65/5 65/9 67/5 71/17 71/22 135/19 137/10 138/3 138/14 186/3 198/23 200/23 201/11 202/8</p> <p>outcomes [12] 28/6 28/6 28/21 28/22 54/12 99/25 100/14 100/23 103/21 104/8 106/24 109/13</p> <p>outlined [1] 152/23</p> <p>outpatient [1] 33/23</p> <p>outset [2] 48/7 104/20</p> <p>outside [10] 13/24 26/16 101/18 126/22 126/23 129/24 131/12 152/2 173/19 174/21</p> <p>over [24] 9/15 19/16 26/25 31/21 61/25 79/23 80/22 82/12 83/20 89/18 102/10 105/16 112/17 129/9 129/23 143/9 145/15 168/21 170/9 170/11 174/14 176/20 182/15 190/16</p> <p>overall [9] 22/23 24/15 40/5 51/9 51/14 51/21 93/24 118/17 160/1</p> <p>overarching [1] 179/3</p> <p>overlaid [1] 78/3</p> <p>overmedicalise [1] 106/2</p> <p>overnight [1] 158/7</p> <p>overseen [1] 118/8</p> <p>oversight [3] 31/13 31/14 98/16</p> <p>overstate [1] 14/10</p> <p>overwhelm [1] 14/6</p> <p>overwhelmed [18] 3/5 13/19 14/1 14/22 15/4 15/5 15/8 15/20 15/23 108/16 108/17 109/4 134/9 134/10 134/11 134/13 134/15</p>	<p>134/17</p> <p>own [13] 44/1 45/20 56/17 73/25 79/19 79/21 81/21 87/12 94/13 95/25 120/18 124/16 167/4</p> <hr/> <p>P</p> <p>pace [2] 104/1 204/8</p> <p>page [16] 39/9 64/1 74/20 76/10 110/21 115/1 129/9 135/15 138/18 170/11 170/11 170/16 176/16 188/6 201/23 205/2</p> <p>page 2 [2] 135/15 170/11</p> <p>page 3 [2] 170/16 201/23</p> <p>page 45 [1] 115/1</p> <p>page 6 [1] 188/6</p> <p>page 78 [1] 110/21</p> <p>page 8 [2] 76/10 138/18</p> <p>Page 9 [1] 176/16</p> <p>Paget [3] 54/9 107/5 179/2</p> <p>Paget's [1] 22/5</p> <p>paid [1] 183/14</p> <p>pain [1] 9/12</p> <p>pandemic [106] 5/3 5/10 5/20 6/6 8/5 8/22 9/21 10/12 10/15 11/17 12/18 13/1 17/8 19/6 19/12 19/21 21/11 23/5 24/14 28/3 28/19 29/4 34/14 34/15 36/22 37/19 37/22 37/23 37/25 38/12 39/12 39/13 41/15 43/6 47/21 50/10 58/4 61/16 62/21 63/5 66/5 67/10 70/6 75/7 77/2 80/6 80/22 81/23 83/5 83/13 84/22 89/2 97/3 99/13 99/22 100/15 101/2 101/3 101/6 101/11 101/13 103/25 104/15 104/18 112/5 116/18 116/20 117/8 117/10 118/11 118/23 119/11 120/19 121/1 122/21 125/5 125/6 125/10 127/1 127/4 131/14 131/21 147/7 148/19 149/17 150/3 160/12 163/24 173/7 175/17 176/8 177/23 178/19 178/22 178/25 179/4 179/11 180/14 183/1 187/4 191/4 198/19 199/13 199/15 200/9 202/18</p>	<p>pandemics [1] 71/4</p> <p>paper [2] 146/18 146/21</p> <p>paragraph [22] 13/11 13/14 50/23 51/4 52/20 58/3 58/13 58/16 76/19 86/11 88/9 97/1 99/6 112/14 113/1 162/17 171/17 176/10 183/16 183/24 193/7 195/23</p> <p>paragraph 138 [1] 86/11</p> <p>paragraph 160 [1] 99/6</p> <p>paragraph 164 [1] 76/19</p> <p>paragraph 252 [1] 193/7</p> <p>paragraph 258 [1] 183/16</p> <p>paragraph 263 [1] 183/24</p> <p>paragraph 277 [1] 195/23</p> <p>paragraph 292 [1] 162/17</p> <p>paragraph 295 [1] 58/3</p> <p>paragraph 296 [1] 58/16</p> <p>Paragraph 3.25 [1] 97/1</p> <p>paragraph 303 [1] 113/1</p> <p>paragraph 304 [1] 112/14</p> <p>paragraph 317 [1] 88/9</p> <p>paragraph 345 [2] 50/23 51/4</p> <p>paragraph 58 [2] 13/11 13/14</p> <p>paragraph 69 [1] 176/10</p> <p>paragraphs [2] 16/7 101/5</p> <p>paragraphs 108 [1] 16/7</p> <p>parallel [1] 91/9</p> <p>parameters [1] 200/9</p> <p>parent [4] 81/22 81/22 96/21 182/18</p> <p>parents [7] 182/25 183/4 183/10 183/10 184/2 184/6 184/7</p> <p>parity [1] 76/14</p> <p>part [50] 3/9 3/18 11/9 12/4 14/17 14/20 14/21 16/4 16/23 21/25 23/7 31/16 31/20 34/15 36/18 37/4 42/13 42/14 43/9 44/10 46/1 48/15</p>	<p>50/17 50/18 52/1 59/24 61/13 61/15 67/25 72/15 74/4 75/14 76/18 80/21 82/3 82/20 87/24 90/13 90/17 91/12 94/21 100/15 100/21 114/4 125/5 142/22 165/11 173/17 180/4 203/4</p> <p>participants [2] 84/8 85/22</p> <p>particular [49] 6/14 7/17 10/20 16/1 33/8 41/22 53/2 65/1 67/22 68/20 69/17 74/12 82/2 82/20 87/3 88/8 94/15 94/16 95/23 96/8 98/12 99/16 100/5 102/3 105/11 105/14 107/1 108/23 115/1 115/20 115/23 126/17 128/20 130/13 132/8 133/3 135/5 138/3 140/9 140/25 153/6 162/5 165/16 175/21 181/4 184/15 186/6 188/13 198/7</p> <p>particularly [30] 33/13 36/22 45/1 47/15 70/15 73/1 81/9 83/2 97/3 97/9 105/25 113/17 114/14 118/10 128/1 132/7 140/12 141/14 142/21 147/11 147/16 149/23 150/7 155/6 166/15 174/10 177/11 177/15 181/21 198/7</p> <p>partly [4] 20/3 23/15 28/23 110/6</p> <p>partner [4] 81/18 97/7 97/15 143/8</p> <p>partners [4] 143/11 143/14 143/15 184/2</p> <p>partnership [3] 4/2 56/12 91/7</p> <p>parts [20] 14/2 15/24 17/18 18/8 23/15 25/11 25/12 29/6 33/24 39/21 44/15 45/3 91/20 92/2 111/8 111/17 117/2 118/11 147/6 166/9</p> <p>pass [1] 42/2</p> <p>pathway [2] 159/9 189/2</p> <p>patient [22] 16/15 54/12 54/16 54/19 55/20 79/22 106/14 119/22 128/4 129/19 135/25 136/4 136/6 137/8 137/8 153/15 154/12 156/12 170/19</p>
--	---	--	--	---

P	148/22 149/3 151/5 160/23 162/5 162/5 198/2	97/8 97/18 98/3 98/15 101/13 101/22 101/25 102/22 104/3 110/8 112/2 121/19 123/18 139/11 140/17 141/16 142/18 142/22 142/22 143/25 152/6 155/16 156/15 163/14 163/21 163/24 164/22 165/1 176/2 177/1 177/15 179/23 180/2 181/9 184/5 187/12 189/23 196/13 199/1	91/4 93/8 98/4 99/14 107/6 108/4 113/1 116/23 116/25 123/3 123/5 127/25 129/14 131/21 131/25 135/8 140/15 140/23 152/5 152/8 153/17 167/8 168/15 170/2 170/12 170/17 170/23 189/16 200/2 202/6 pointing [2] 6/4 67/22 points [14] 1/16 5/17 34/23 66/19 68/25 70/21 78/15 93/22 97/22 102/19 118/16 121/1 141/14 183/18 poke [1] 42/6 police [1] 102/4 policies [3] 124/16 165/2 167/5 policy [16] 2/9 80/16 81/1 112/15 162/22 162/23 163/2 163/12 164/13 165/1 167/3 167/4 187/8 193/22 201/1 201/2 policy-making [1] 201/2 politician [1] 161/21 poor [7] 74/25 75/1 75/7 75/17 181/2 203/8 203/12 poorer [1] 147/5 poorly [1] 43/18 poorly-fitted [1] 43/18 population [17] 19/8 51/24 75/13 78/4 84/10 94/2 95/12 100/2 100/9 100/11 103/14 107/10 145/5 146/25 147/5 147/24 181/7 portable [3] 65/7 70/16 194/18 portfolio [2] 117/9 123/7 portion [1] 39/19 posed [2] 117/7 201/18 position [15] 19/20 24/21 30/3 30/22 40/1 47/6 59/6 67/15 68/12 69/3 79/19 86/10 86/22 92/3 151/15 positive [6] 56/16 64/3 64/16 64/17 100/24 135/20 positively [1] 196/12 positives [1] 181/17 possibility [1] 175/10 possible [12] 23/12 23/17 23/18 45/21	49/23 50/17 51/11 85/12 98/9 112/4 144/3 152/2 possibly [2] 63/3 189/20 post [6] 7/22 135/7 144/14 151/10 167/23 168/20 potential [11] 45/19 65/9 69/20 73/9 111/16 136/10 136/14 138/8 152/12 194/22 194/25 potentially [8] 9/5 11/16 14/15 19/11 57/13 93/2 93/18 138/6 power [1] 2/19 powers [4] 124/9 125/7 125/18 125/18 PPE [44] 4/2 34/2 34/4 34/19 34/25 35/2 35/5 35/10 36/7 36/15 36/17 37/11 37/21 38/6 38/7 38/23 40/19 42/9 42/13 42/18 43/19 45/7 45/19 45/22 47/18 61/2 64/10 64/22 82/17 83/12 85/5 88/4 88/13 88/20 89/18 89/25 90/1 90/6 90/11 91/1 91/4 91/12 137/20 139/18 practicably [1] 196/24 practical [9] 57/8 76/5 76/7 76/7 82/15 113/11 115/25 171/19 189/3 practically [1] 11/23 practice [25] 2/7 4/6 4/19 10/24 61/2 61/14 61/19 62/23 63/7 66/24 68/7 68/22 70/3 70/9 80/14 80/17 81/5 82/13 84/25 95/17 98/20 119/14 119/18 120/11 190/1 pre [11] 5/9 9/21 19/12 19/21 28/3 28/19 29/4 37/19 59/1 61/16 136/3 pre-ordered [1] 59/1 pre-pandemic [7] 9/21 19/12 19/21 28/3 28/19 37/19 61/16 precaution [1] 152/10 precautionary [3] 193/22 193/25 194/1 precautions [2] 12/15 153/16 precise [1] 138/10
----------	---	---	--	--

P	140/21 158/9 priorities [7] 76/8 123/7 123/9 123/21 123/24 124/5 144/12 prioritisation [1] 16/15 prioritising [1] 105/20 priority [2] 63/6 184/13 private [10] 24/18 44/23 95/9 146/4 146/5 146/6 146/9 146/10 146/12 150/10 proactively [2] 188/12 189/16 probable [2] 63/20 135/12 probably [20] 7/7 29/24 33/24 39/9 44/16 128/11 137/14 139/4 144/4 144/10 153/23 155/25 156/5 166/24 177/20 180/1 184/16 189/15 190/22 192/22 problem [21] 7/14 8/10 12/2 33/14 43/8 45/25 57/7 87/5 89/9 104/3 136/17 137/11 139/7 145/1 145/25 146/3 147/16 173/8 174/6 203/10 203/12 problems [12] 7/2 41/22 41/24 67/3 95/16 99/17 115/22 167/15 167/19 168/17 202/1 202/3 process [10] 15/24 46/3 46/10 46/25 94/18 128/21 136/3 156/24 166/8 166/18 processes [5] 155/16 164/22 165/4 189/22 196/13 processing [1] 116/17 procure [2] 40/15 91/22 procured [3] 46/2 46/12 90/12 procurement [5] 41/8 44/12 47/2 91/4 91/17 procuring [2] 38/23 91/15 prod [1] 42/7 produce [1] 106/25 produced [3] 61/5 179/3 189/1 products [1] 44/15 professional [2] 142/23 142/25 Professionals [1]	175/24 Professor [16] 25/16 98/25 102/20 102/21 109/22 110/2 113/17 148/5 148/10 148/17 166/11 194/20 199/1 200/4 201/4 205/11 Professor Beggs [1] 194/20 Professor Fong [4] 109/22 110/2 199/1 200/4 Professor Fu-Meng Khaw [1] 201/4 Professor Keshav [1] 102/21 Professor Kloer [1] 113/17 Professor Metcalfe [3] 148/5 148/10 148/17 PROFESSOR THOMAS [2] 98/25 205/11 Professor White [1] 25/16 Professor Wyllie [1] 166/11 Professors [4] 11/2 107/12 158/12 158/15 profile [1] 164/11 programme [31] 98/15 113/3 123/11 123/13 123/16 137/3 150/1 151/9 151/23 153/10 153/17 153/21 154/9 154/22 155/3 156/2 156/2 157/2 157/3 157/18 157/22 158/10 159/12 166/5 175/23 188/4 190/3 195/19 196/4 197/25 199/9 progress [1] 176/13 project [1] 156/23 projected [1] 145/10 promise [2] 121/19 122/7 prompt [3] 12/20 150/5 196/13 promptly [1] 164/20 proper [2] 97/15 139/18 properly [13] 46/3 64/10 64/21 64/21 89/19 91/16 97/14 104/14 111/9 120/19 188/18 195/3 202/25 proportion [3] 48/3 51/20 130/2 proportionate [1] 185/19 proportionately [1] 180/17	proposals [2] 171/21 187/8 protect [10] 13/12 13/14 37/16 67/4 67/7 89/19 101/22 123/17 152/16 154/17 protection [4] 35/3 41/17 88/8 152/9 protections [2] 140/17 154/10 protective [3] 34/5 35/15 38/14 protectors [1] 38/10 provide [20] 20/19 21/15 21/15 21/19 31/15 31/19 31/22 31/24 44/1 50/6 56/20 101/24 110/22 146/1 146/2 159/4 162/10 175/8 193/10 193/13 provided [29] 5/22 23/25 28/9 50/4 51/4 54/22 63/12 83/18 91/20 99/20 105/14 106/19 113/16 127/18 129/13 135/10 137/5 137/16 142/13 146/23 148/6 156/8 157/14 158/13 167/24 171/14 171/25 185/13 186/8 providers [1] 141/7 providing [11] 28/15 31/13 51/10 95/21 95/23 113/2 124/19 156/16 188/18 193/22 203/22 provision [5] 97/2 97/8 118/10 146/14 188/9 provoked [1] 77/21 prudent [1] 106/1 Prynhawn [1] 198/14 psychological [1] 94/19 public [28] 3/13 7/1 14/24 18/17 22/18 59/2 61/4 64/2 77/9 78/17 99/11 99/21 99/22 99/24 99/24 100/2 102/3 103/22 104/10 116/23 135/11 138/12 145/14 156/9 160/24 170/24 199/9 201/4 Public Health Wales [7] 59/2 61/4 64/2 78/17 135/11 156/9 201/4 publication [3] 41/3 42/19 45/9 publicly [2] 81/4 88/10 published [8] 16/6 16/12 49/8 69/23	77/12 83/20 97/23 156/10 pull [2] 158/8 179/8 pulled [1] 179/18 pulling [1] 179/20 pulse [2] 198/25 200/2 purchaser [1] 91/6 purchasing [1] 39/22 purely [1] 133/20 purpose [6] 6/3 38/10 56/16 77/5 77/6 88/15 purposes [1] 63/16 pursued [1] 75/10 push [1] 32/6 put [23] 15/2 19/9 32/16 42/17 63/11 67/18 85/17 88/5 92/17 94/17 97/18 107/23 139/10 149/18 158/1 163/14 175/23 176/2 183/7 189/11 189/12 189/23 190/10 putting [4] 40/1 56/22 136/1 185/11
			Q	
			quality [13] 9/14 10/16 28/9 44/25 75/1 75/7 75/19 75/20 76/12 116/23 201/5 201/7 201/10 quarters [1] 149/3 question [28] 27/3 61/9 62/6 62/20 85/1 86/20 87/20 97/17 101/9 102/9 103/19 109/15 114/6 124/4 128/15 149/15 155/8 164/5 185/10 186/17 189/7 189/10 189/15 189/18 191/12 192/11 197/14 201/25 question 12 [1] 201/25 questioning [1] 116/8 questions [64] 1/9 20/14 37/1 37/2 57/13 72/3 85/20 85/21 85/24 86/3 92/7 92/10 92/12 92/14 92/16 96/16 96/19 98/25 105/2 105/5 105/8 105/11 108/11 108/15 120/23 121/11 122/10 151/7 182/12 182/16 184/25 185/4 185/5 187/16 187/19 187/21 190/17 190/19 193/15 197/5 197/8 197/9 197/13 198/13 198/15 201/18 203/9 204/2	

Q				
questions... [16] 204/5 204/7 205/4 205/6 205/8 205/9 205/10 205/12 205/13 205/15 205/17 205/18 205/19 205/21 205/22 205/23 quick [1] 88/13 quickly [11] 21/7 34/8 38/15 72/1 86/8 130/15 149/22 156/25 171/4 181/18 182/8 quite [28] 2/9 11/3 19/13 34/7 34/10 63/3 73/6 84/23 86/5 98/11 110/14 111/23 128/15 130/8 130/11 131/20 133/6 133/15 138/10 139/22 141/6 144/25 147/10 161/9 176/4 179/22 196/16 196/21 quotations [1] 29/11	95/17 118/1 123/6 128/22 136/15 138/2 147/22 164/1 165/3 171/12 176/19 177/7 198/4 ratio [4] 26/13 26/16 26/16 29/7 rationale [1] 53/21 ratios [13] 15/6 25/14 26/12 27/2 27/24 28/8 28/12 28/16 28/21 29/7 131/2 131/5 131/10 RCN [3] 4/1 45/11 191/4 re [5] 3/4 8/20 33/12 80/17 81/3 re-establishment [1] 33/12 re-issue [1] 80/17 re-issued [1] 81/3 re-organise [2] 3/4 8/20 reach [1] 103/11 reached [1] 92/3 reaching [1] 36/17 read [3] 30/8 101/14 115/8 readily [1] 60/5 reading [1] 138/21 ready [3] 17/12 103/17 169/13 reagents [1] 59/3 real [34] 9/13 17/2 17/16 18/18 25/5 32/8 35/11 35/11 36/8 41/2 41/22 43/12 45/1 45/25 46/7 56/17 60/4 67/11 69/3 70/6 72/22 76/7 82/6 85/12 89/9 89/18 90/13 90/13 115/22 118/15 150/8 159/17 178/2 181/15 realisation [2] 17/22 20/16 realise [1] 134/4 realistic [1] 11/9 reality [3] 77/9 91/2 106/8 really [62] 5/19 8/21 13/15 13/17 13/21 14/12 14/13 24/25 25/1 27/21 32/15 33/17 34/7 35/22 36/12 37/14 44/7 49/23 53/19 55/21 56/25 60/22 62/6 65/14 65/20 73/3 78/23 85/16 85/18 93/11 101/13 109/20 114/18 117/19 121/16 128/12 129/14 133/6 133/10 133/14 134/4 134/22 138/5 142/20	144/23 147/19 149/24 150/12 152/9 152/18 156/3 163/9 173/9 173/16 175/4 179/21 179/24 181/18 181/19 182/8 182/8 199/20 realtime [1] 24/5 reason [13] 8/12 20/3 21/25 37/5 43/9 44/10 67/6 70/23 76/8 118/11 173/14 190/10 195/10 reasonable [12] 18/11 18/20 18/24 20/2 21/24 22/12 22/14 22/25 31/18 94/19 95/4 97/14 reasonably [1] 197/1 reasons [7] 83/15 86/14 144/15 166/17 174/10 183/13 184/12 reassurance [2] 152/15 154/2 Rebecca [1] 153/8 recall [19] 3/5 6/13 19/3 47/11 48/13 51/15 52/12 64/25 65/1 65/21 66/1 70/18 71/18 112/12 114/2 183/21 193/17 196/12 202/5 receipt [1] 83/25 receive [4] 11/16 69/7 69/11 70/14 received [13] 45/4 53/12 53/22 64/19 106/12 109/5 111/21 127/15 151/14 155/18 169/6 171/10 176/18 receiving [10] 6/13 110/4 131/12 131/16 131/16 144/3 145/12 145/17 197/22 200/6 recognise [4] 29/8 68/23 104/15 191/6 recognised [3] 79/24 160/24 184/1 recognising [1] 176/5 recognition [1] 191/16 recommend [3] 107/14 159/15 160/3 recommendation [8] 35/4 76/11 85/2 85/6 115/3 115/8 115/14 116/1 recommendations [10] 16/13 16/24 34/25 97/11 97/24 114/25 115/2 115/13 139/3 178/24 recommended [1] 105/22	recommending [1] 159/3 record [4] 55/19 55/20 178/12 188/5 recorded [3] 66/11 200/23 202/22 recording [3] 76/13 166/19 202/17 records [1] 56/7 recover [1] 148/19 recovering [3] 51/9 51/14 155/21 recovery [8] 12/21 33/21 48/4 144/13 144/18 148/11 150/5 157/16 recruit [3] 77/7 147/10 173/12 recruiting [1] 132/8 recruitment [1] 169/11 red [4] 12/9 12/14 168/4 197/21 redeploy [2] 20/10 111/8 redeployed [3] 25/19 47/16 102/7 redesigns [1] 192/17 reduce [5] 67/19 145/12 145/16 170/18 180/15 reduced [3] 18/24 118/15 133/16 reducing [5] 20/9 81/14 82/22 143/23 180/21 reduction [2] 9/13 172/24 Rees [1] 43/23 refer [3] 146/17 176/11 193/8 reference [5] 64/2 136/6 188/5 189/5 201/18 references [1] 26/11 referral [1] 196/11 referrals [2] 105/17 105/21 referred [12] 53/24 105/12 106/13 154/19 159/16 159/18 159/20 162/22 164/4 189/7 194/20 197/20 referring [1] 164/16 reflect [6] 35/22 109/11 109/17 109/24 111/15 179/10 reflected [3] 82/9 109/5 187/14 reflecting [2] 24/3 93/6 reflection [1] 107/18 reflective [1] 76/2 reflects [1] 111/17	reform [2] 10/8 10/14 refreshing [1] 169/3 refurbished [1] 119/20 refuse [1] 36/19 regarding [1] 197/15 regardless [1] 121/2 regime [2] 114/7 115/11 regional [2] 147/21 148/2 register [1] 97/13 regular [19] 11/25 23/3 23/6 24/8 42/17 43/6 47/13 47/14 50/16 60/14 61/15 79/13 84/17 95/14 115/5 115/11 126/1 127/15 132/13 regularised [2] 44/14 45/2 regularly [6] 19/22 74/2 127/9 127/10 144/25 187/8 rehab [3] 48/15 48/21 54/25 rehabilitation [9] 33/20 48/17 49/2 49/12 51/7 105/13 105/20 106/9 198/4 reinforcement [1] 63/7 reinstate [4] 152/4 153/10 153/21 154/22 reinstated [3] 151/12 151/24 153/17 reinstating [1] 151/18 reiterate [1] 62/22 reiterated [1] 81/3 reiterating [1] 153/16 reiterating: [1] 67/6 reiterating: there [1] 67/6 reiteration [1] 65/10 related [3] 35/4 69/6 184/14 relation [14] 78/11 123/6 123/14 123/16 139/11 140/25 143/21 147/2 165/21 181/20 186/2 191/7 198/8 199/12 Relations [1] 122/22 relationship [1] 91/11 relationships [1] 26/6 relative [3] 191/1 192/3 192/13 relatively [12] 51/8 51/13 52/9 52/19 105/10 123/5 192/16 192/22 193/21 195/1

R	44/2 60/1 65/23 73/18 84/17 116/12 138/13 157/5 164/11 179/16 180/3 represent [6] 96/20 108/20 182/17 188/1 196/8 202/7 representation [1] 195/24 representative [4] 29/17 106/14 186/19 187/6 representatives [2] 54/20 183/19 represented [1] 187/11 representing [3] 45/12 99/4 185/7 represents [1] 63/21 reprimanded [1] 43/22 request [13] 6/13 6/16 7/17 142/13 153/9 169/25 170/17 172/12 172/13 172/17 172/20 172/22 178/14 requested [4] 168/1 170/12 171/13 172/4 requesting [2] 169/7 193/9 requests [5] 70/14 97/13 169/20 169/21 169/23 require [5] 33/16 51/22 117/23 177/6 192/25 required [12] 18/14 18/25 19/11 20/21 32/8 55/7 155/19 157/5 172/6 186/7 193/14 196/10 requirement [1] 94/11 requirements [2] 97/13 98/6 requires [7] 19/16 33/15 75/20 75/21 107/17 136/8 198/5 requiring [2] 49/24 184/6 research [2] 29/12 158/1 researchers [1] 29/19 reserve [1] 34/15 resilience [1] 124/24 resolved [2] 4/10 41/25 resort [1] 43/17 resource [2] 89/19 118/14 resources [3] 20/11 25/18 67/5 respect [5] 10/11	89/10 106/10 107/12 166/8 respected [1] 104/6 respective [1] 12/6 respectively [1] 35/22 respiratory [2] 30/20 41/19 respond [5] 16/25 142/2 144/9 164/9 201/11 responded [1] 65/25 responding [3] 169/1 196/3 199/16 response [26] 2/5 18/17 22/18 42/8 62/4 62/7 64/25 65/18 75/21 76/18 77/3 80/9 85/4 125/7 125/10 141/8 162/21 164/8 167/18 168/17 170/21 179/4 193/12 193/15 197/4 201/20 responses [3] 75/23 76/6 193/17 responsibilities [5] 2/1 2/4 2/6 124/9 126/10 responsibility [10] 22/24 46/22 50/8 111/4 111/5 124/12 124/14 124/22 182/4 182/4 responsible [13] 2/15 11/12 31/11 32/15 34/4 56/22 91/18 95/6 95/7 140/9 141/20 143/6 175/21 rest [2] 42/16 160/24 restart [7] 6/16 9/19 10/17 11/22 11/23 12/4 13/5 restarted [2] 9/25 69/19 restarting [3] 9/12 12/1 34/1 restoration [1] 148/8 restore [1] 148/21 restricted [2] 142/7 181/15 restriction [1] 203/15 restrictions [16] 81/7 81/9 81/12 97/7 141/3 141/15 141/16 142/17 143/20 151/22 152/5 182/20 182/22 185/17 186/1 186/4 result [13] 64/14 72/16 101/15 155/7 166/1 178/8 181/18 189/4 190/2 199/15 200/20 202/9 202/10 resulted [2] 9/12 75/1	results [3] 114/18 159/19 160/7 resume [1] 9/21 resumption [1] 10/21 Resuscitation [1] 166/7 retain [1] 77/7 retained [1] 124/22 retrain [2] 20/11 21/1 retrofitted [1] 119/18 retrofitting [2] 71/9 192/18 retrospect [3] 126/18 178/19 186/21 retrovirals [1] 154/3 return [4] 57/17 93/18 116/7 121/23 revealed [1] 60/22 review [15] 67/21 82/12 126/7 140/16 163/16 163/21 163/22 163/24 165/6 165/20 165/21 168/7 179/8 180/9 199/4 reviewed [2] 138/12 157/3 reviewing [1] 157/19 revisited [1] 106/20 reward [1] 79/25 rid [3] 161/11 180/19 180/20 right [70] 2/3 2/9 2/18 7/10 7/19 9/5 17/15 19/24 26/12 32/3 37/17 38/6 38/7 39/1 44/5 45/7 47/13 52/15 52/24 53/6 53/19 53/21 54/14 57/24 59/6 59/12 59/16 62/6 63/9 71/12 81/12 83/17 84/24 86/18 88/3 94/23 104/13 120/14 121/9 122/19 122/24 125/17 125/19 127/14 129/22 136/2 137/2 140/17 143/21 143/25 144/10 151/8 151/13 153/8 157/9 162/15 165/24 167/17 168/14 171/10 172/12 179/18 183/8 183/13 183/16 183/23 189/11 189/13 195/14 202/20 right-hand [1] 129/22 rights [3] 83/19 84/18 185/7 rigorous [3] 61/20 62/22 63/7 rigour [2] 65/19 121/5 ring [1] 85/15 ripple [3] 14/17 14/19 14/22 rise [1] 12/3	rising [1] 114/15 risk [63] 28/7 28/20 28/22 43/21 45/19 56/13 75/2 76/1 76/3 77/19 77/21 81/14 82/18 82/19 82/19 82/22 83/6 93/5 93/8 93/14 93/22 94/12 94/14 96/8 96/12 99/7 99/14 99/19 100/4 100/7 100/8 100/9 100/10 102/1 102/5 102/8 102/21 140/1 142/23 152/7 153/7 161/24 170/21 171/5 176/9 176/10 176/14 176/17 176/18 176/22 176/25 177/4 177/6 177/17 177/19 191/1 191/14 191/24 195/2 195/22 196/14 196/18 196/25 risks [3] 93/1 96/1 143/24 robust [1] 77/3 Roche [1] 58/14 role [11] 2/1 68/21 122/17 122/23 123/2 124/17 175/20 186/14 191/6 191/16 192/9 roll [3] 61/22 113/15 125/12 roll-out [2] 113/15 125/12 rolled [4] 113/15 113/18 114/8 115/11 room [7] 53/7 72/3 186/20 190/23 191/14 191/15 194/19 rooms [1] 119/6 round [1] 5/17 rounded [1] 94/1 routine [2] 9/19 112/15 rows [1] 6/24 royal [17] 3/24 3/25 5/21 5/25 6/2 6/6 6/8 6/8 6/11 6/11 6/15 7/17 12/10 79/2 134/20 193/8 203/6 rules [4] 127/5 137/21 140/19 141/19 run [13] 15/22 27/2 35/10 36/7 37/14 40/5 40/6 40/12 42/12 49/18 49/20 79/20 90/6 running [6] 4/20 8/11 36/22 38/15 89/15 118/2 rural [2] 147/11 181/21 Russell [1] 164/6
----------	---	--	---	---

S			
safeguarding [1] 81/25	168/14 168/19 168/20 176/3 184/10 187/13 192/6 192/19 194/11 204/5	146/7 146/9 146/10 167/16 169/9 174/7 174/10 175/7	124/8 127/3 133/2 133/23 142/4 142/9 153/4 154/16 167/2 173/5 179/18 180/3 180/21 181/1 200/10
safely [3] 12/25 13/3 46/12	saying [9] 10/19 22/1 43/8 63/4 82/19 94/8 99/17 133/5 194/12	sectors [1] 174/8	sensible [5] 4/8 49/17 100/17 100/20 100/20
safety [6] 136/4 136/7 137/9 188/14 192/3 192/13	says [7] 21/12 30/14 41/15 51/12 75/14 128/5 171/16	secure [1] 91/19	sensitive [7] 102/18 103/17 109/14 109/17 142/11 143/1 156/3
safety' [1] 135/25	scale [4] 12/24 32/7 57/7 82/4	securing [1] 196/11	sensitivities [1] 102/25
said [36] 5/23 7/25 9/11 10/17 20/5 25/13 25/15 26/14 27/7 35/6 39/23 39/24 49/3 72/14 72/22 77/5 82/14 88/3 88/16 90/12 91/10 94/9 108/17 109/8 112/19 114/2 145/12 159/14 164/18 168/23 178/1 180/7 185/12 186/21 195/15 201/24	scan [2] 82/21 83/1	see [57] 6/23 7/1 7/3 7/10 12/5 12/8 21/5 24/3 29/21 31/21 33/7 34/22 36/23 39/3 39/5 39/10 42/11 50/14 53/25 61/23 62/14 63/18 63/24 66/24 68/16 73/25 83/5 83/6 85/25 87/3 89/5 89/10 99/1 99/3 114/11 119/18 127/20 129/10 129/12 129/15 129/19 129/21 130/3 132/10 135/11 135/15 135/22 136/5 150/22 159/3 160/8 160/14 170/2 181/12 195/14 200/14 200/17	sent [7] 41/13 128/12 138/12 193/8 196/2 196/20 203/7
said aprons [1] 39/23	Scanning [1] 156/10	seeing [3] 25/8 40/17 83/4	separate [6] 83/14 111/2 144/23 147/17 150/7 181/11
sake [1] 57/5	scans [3] 81/23 83/8 83/11	seek [2] 154/25 164/21	separately [2] 40/17 149/17
same [24] 4/11 4/12 17/13 28/15 28/18 29/3 29/8 30/22 44/13 74/6 87/8 100/7 104/5 104/6 119/21 142/24 145/8 157/25 173/21 184/7 189/15 189/18 189/19 198/18	scenario [9] 15/12 18/12 18/24 20/2 21/24 22/13 22/14 23/1 37/15	seeking [2] 165/3 175/7	separation [2] 119/14 181/5
sample [2] 163/15 163/21	scenarios [2] 18/21 31/19	seem [3] 78/21 131/15 173/8	September [8] 24/16 93/5 117/9 138/14 169/23 171/11 172/20 176/11
sanitiser [1] 44/16	school [2] 92/25 93/4	seemed [5] 4/14 49/17 142/18 157/12 177/12	September 2014 [1] 117/9
satisfaction [2] 159/13 160/10	school's [1] 43/25	seems [1] 191/20	September 2020-April 2021 [1] 138/14
satisfactory [2] 151/3 151/4	science [3] 18/16 157/20 157/25	seen [16] 14/9 15/8 15/9 23/24 44/6 64/13 65/15 67/13 68/10 79/7 88/19 88/21 89/13 129/10 142/20 161/23	series [4] 8/23 75/23 124/3 169/19
satisfied [5] 22/21 47/6 98/20 160/4 160/5	Scientific [4] 3/24 60/1 110/11 113/2	segregation [1] 77/24	serious [3] 48/3 91/2 104/10
save [3] 15/11 117/23 172/6	scope [1] 32/7	self [5] 52/18 56/6 97/13 135/16 155/8	seriously [4] 28/25 43/10 96/12 164/20
saved [1] 108/22	Scotland [3] 166/9 171/22 199/9	self-isolate [1] 155/8	servant [1] 116/23
saw [16] 14/5 16/2 24/9 36/17 40/22 69/16 74/1 78/14 88/17 89/22 114/9 131/13 141/5 142/6 143/2 169/1	Scott [1] 148/5	self-register [1] 97/13	served [1] 122/17
say [49] 2/23 3/15 5/16 7/16 8/2 18/2 19/1 23/13 23/21 24/13 25/21 26/21 31/10 34/3 36/6 36/10 42/2 42/7 42/10 43/2 43/15 49/1 52/25 56/16 56/21 59/18 79/10 80/1 83/9 85/14 87/8 106/5 119/10 119/20 120/7 128/16 138/9 161/21 167/17	screen [13] 6/22 7/4 16/9 16/11 29/14 38/21 41/12 51/1 63/11 74/18 84/14 114/19 201/16	self-reported [2] 52/18 135/16	service [56] 3/4 4/24 4/25 5/9 5/19 8/15 8/17 8/18 8/19 10/8 10/14 13/25 14/18 14/20 15/8 15/25 15/25 17/19 18/8 25/11 36/2 37/5 61/13 66/25 67/1 67/8 68/19 75/11 76/5 76/9 77/8 78/5 79/20 84/8 85/16 91/22 101/18 102/2 103/5 104/4 104/8 106/24 107/9 117/25 118/1 123/24 145/5 145/6 159/22 159/25 162/8 173/18 174/4 174/11 175/6 191/9
	screening [1] 2/5	send [1] 151/5	services [65] 1/22 3/4 3/14 15/7 16/16 47/2 49/15 49/20 49/22 50/5 51/22 53/25 76/14 83/23 84/13 91/7 95/6 96/7
	screens [6] 14/10 88/17 89/22 101/24 119/1 119/13	sender [1] 41/15	
	screenshots [1] 110/22	sending [1] 20/17	
	scrutiny [4] 32/8 115/16 198/19 199/12	Senedd [9] 1/19 134/20 134/21 153/9 154/24 162/16 164/5 193/16 203/10	
	seasonal [1] 170/7	Senedd's [1] 114/21	
	second [19] 23/8 26/15 32/12 33/4 33/6 47/11 53/1 67/13 69/16 73/7 88/4 89/12 123/3 172/22 189/15 189/16 200/1 200/22 201/24	senior [2] 59/24 90/5	
	secondary [5] 49/25 105/18 159/16 181/21 197/21	sense [19] 8/21 33/22 65/17 67/3	
	secondly [1] 141/22		
	secret [1] 67/2		
	secretary [3] 1/20 54/15 108/6		
	section [1] 74/23		
	sector [15] 44/23 73/16 95/9 115/23 145/20 146/4 146/6		
			102/3 102/4 102/4 105/12 106/9 119/23 122/15 123/3 123/6 123/8 124/10 126/13 139/13 143/5 144/13 144/21 148/21 151/11 155/15 155/20 157/10 157/13 158/20 159/11 159/14 159/23 162/2 168/2 168/12 168/13 169/17 169/22 170/4 170/24 172/5 172/16 175/9 179/2 188/7 188/9 188/11 188/18 189/17 192/6 193/5 194/4 194/16
			Services' [1] 170/13
			set [43] 2/1 2/9 16/13 24/24 27/23 32/6 38/1 52/5 53/9 53/21 58/3 58/4 58/16 60/13 61/10 62/9 62/19 62/21 63/23 71/16 72/13 75/23 76/18 81/8 120/2 124/10 126/20 128/14 138/11 140/11 141/5 152/22 153/6 168/10 169/4 176/13 186/15 189/2 190/2 192/4 192/20 196/4 201/5
			set-up [1] 120/2
			sets [3] 63/14 115/9 189/25
			setting [3] 54/3 81/10 171/15
			settings [7] 69/11 140/6 140/17 142/21 193/14 194/6 195/3
			seven [1] 57/14
			several [2] 81/4 156/21
			severely [3] 83/23 154/6 154/13
			severity [1] 99/9
			shall [2] 57/17 121/23
			shape [3] 46/4 46/9 119/7
			shaped [1] 16/21
			shapes [1] 47/8
			Share [1] 91/7
			shared [2] 47/1 119/16
			shares [1] 91/15
			she [10] 22/6 48/22 74/1 80/12 94/8 94/9 94/9 94/10 94/10 153/12
			she's [1] 197/15
			sheer [1] 68/15
			Shepherd [8] 108/10 108/11 121/13 198/12 198/13 204/3 205/13

S	162/11	10/4 18/5 109/5	100/8 101/19 103/3	space [8] 30/1 48/21
Shepherd... [1]	show [3] 24/1 110/24	120/24 120/25 125/6	113/19 115/9 115/12	49/23 55/7 156/6
205/23	111/16	144/22 171/8 199/16	117/14 117/22 120/23	191/1 192/3 200/13
shield [4] 72/12	showed [6] 60/23	situations [1] 15/14	121/15 123/19 125/7	spaces [2] 192/14
152/24 153/1 155/3	61/6 67/15 111/24	Sivakumaran [1]	125/8 125/11 127/12	192/25
shielded [8] 94/2	157/9 176/16	104/24	127/25 128/16 134/17	spacing [1] 137/21
94/10 95/11 151/16	showing [1] 110/23	six [5] 11/6 34/17	138/24 140/19 140/20	speak [6] 10/16 54/5
151/18 151/19 153/15	shown [2] 129/15	34/19 157/4 172/1	141/2 141/9 142/4	127/2 133/10 155/24
154/12	130/1	six months [1] 157/4	142/11 142/21 143/2	177/2
shielding [44] 72/4	shows [4] 32/8 42/1	six months' [1] 34/17	146/12 147/10 149/3	speaking [4] 39/5
72/5 72/11 72/23	42/15 138/15	six weeks [1] 172/1	151/7 151/17 151/17	133/18 134/17 192/22
72/25 73/2 86/9 86/10	shrug [1] 47/3	size [6] 18/7 19/7	152/18 157/9 158/9	speaks [1] 187/6
86/12 86/17 86/21	shut [1] 160/19	26/10 46/4 46/9 118/5	159/22 159/24 162/2	specialised [2] 53/24
87/1 87/10 87/15	shysters [1] 40/20	sizes [1] 47/8	162/6 164/10 164/12	160/10
92/15 92/15 93/9	sick [4] 93/17 93/19	skills [1] 107/17	174/16 174/19 175/12	specialist [15] 49/21
93/15 93/16 93/17	150/24 154/11	skip [1] 102/10	181/17 181/24 182/9	52/3 107/2 107/6
94/18 94/22 94/25	sicker [1] 147/5	sleeves [2] 61/22	182/19 185/24 192/22	107/15 107/18 139/12
95/20 139/25 140/5	sickness [2] 174/6	61/25	199/21 203/20	159/11 159/17 191/9
151/8 151/8 151/23	175/1	slightly [4] 4/5 69/6	some push [1] 32/6	192/6 193/5 194/4
152/5 152/24 153/10	side [4] 33/21 56/12	100/9 144/7	someone [6] 15/1	194/16 197/23
153/17 153/21 154/9	107/1 129/22	slow [3] 62/7 168/16	74/2 94/8 104/5 120/8	specialists [3] 54/1
154/20 155/3 195/19	significance [1] 17/1	181/12	201/21	54/6 158/11
197/2 199/8 200/14	significant [17] 14/23	small [9] 26/6 43/2	someone's [1] 55/19	specialities [1] 30/23
200/15 200/18 200/20	15/14 17/22 20/17	48/2 51/8 51/13 51/24	something [41] 5/2	specific [20] 6/16
shift [2] 76/7 116/19	39/19 48/2 53/4 66/21	52/9 52/19 53/8	8/18 12/10 20/16 22/2	42/13 47/24 69/13
shifted [2] 31/21 33/4	89/21 90/17 91/12	smaller [3] 32/10	22/18 31/7 42/15 43/9	75/4 80/12 84/2 97/17
shock [1] 13/24	91/21 97/3 117/20	45/12 66/8	48/19 56/10 60/17	98/14 103/16 106/20
shocking [1] 14/10	138/23 170/21 171/5	so [406]	61/19 68/24 75/18	126/16 141/11 142/11
shop [2] 54/2 158/17	significantly [5] 12/3	social [27] 1/22 3/13	82/25 83/3 88/2 88/18	150/4 163/4 186/5
shopping [1] 74/1	25/18 82/23 119/20	37/8 64/14 64/23	89/20 90/24 109/15	186/11 203/2 203/25
short [10] 57/20	148/9	65/13 76/14 91/23	113/23 117/1 121/3	specifically [4] 31/1
58/21 59/4 80/5 86/3	signposting [1]	114/21 114/23 115/6	121/6 125/15 126/5	99/11 143/4 147/3
121/25 142/8 167/11	189/17	115/24 122/14 123/3	126/24 131/13 132/13	specified [2] 143/8
197/14 204/8	similar [5] 64/16	123/6 123/8 123/14	139/4 140/18 148/2	143/14
shortage [3] 47/13	129/10 147/19 171/21	124/10 126/13 146/19	158/6 160/23 164/1	speed [2] 73/6
47/13 88/23	193/15	151/11 152/3 154/21	178/3 184/22 191/2	123/13
shortages [1] 167/20	Simon [1] 35/20	155/15 179/1 185/8	200/2	speedy [1] 197/4
shortly [1] 105/10	Simon Dean [1]	200/20	sometimes [14] 4/7	spend [1] 85/9
should [68] 5/1 9/19	35/20	societal [1] 141/15	4/13 4/18 5/5 43/20	spending [1] 118/1
12/18 15/11 17/3	simple [4] 46/9 47/3	society [3] 13/24	78/21 79/24 127/1	spent [4] 39/17 118/5
37/11 48/23 49/14	76/25 116/5	100/22 178/10	128/17 142/21 147/10	121/15 134/1
49/24 55/25 56/1 56/9	simply [9] 13/7 17/3	socioeconomic [3]	149/4 194/11 194/20	spoke [6] 41/10 55/5
56/21 61/14 62/12	18/12 89/8 115/25	43/13 74/21 104/11	somewhere [1] 22/10	61/17 117/6 127/8
62/13 64/15 66/22	119/9 119/10 120/7	soft [1] 95/17	soon [7] 11/23 62/21	203/19
66/24 68/19 72/1	152/25	sold [1] 94/8	62/21 132/25 133/15	spoken [2] 41/24
79/10 80/23 83/9	since [13] 3/7 5/12	solved [1] 173/8	140/21 183/11	66/7
88/18 88/19 88/21	7/25 99/23 117/9	some [119] 1/17 2/6	sooner [4] 62/10	Sport [1] 1/21
98/11 100/14 106/4	125/16 126/6 126/20	3/1 3/6 4/9 9/13 13/10	148/19 148/23 148/24	sports [2] 114/21
107/7 119/6 119/22	147/25 161/10 168/5	14/11 15/6 15/7 16/3	sophisticated [2]	156/21
127/5 139/21 140/10	181/7 203/11	16/21 18/8 19/4 20/14	196/16 196/21	spread [6] 138/25
143/13 144/4 144/19	since July [1] 168/5	23/24 29/6 30/5 30/17	sorry [6] 6/21 7/12	139/17 139/23 152/12
148/18 149/13 150/3	Singhal [1] 102/21	31/23 32/6 33/23 36/8	105/1 112/19 192/11	152/14 203/7
151/23 154/17 155/22	single [7] 20/6 94/2	36/13 36/14 38/9	200/3	spreading [4] 68/8
157/19 159/4 159/9	103/9 137/13 160/21	38/10 40/22 41/21	sort [8] 22/17 24/2	93/2 191/2 191/15
162/7 162/11 162/23	179/3 199/23	43/16 43/19 43/21	33/21 106/24 118/7	spring [3] 55/3 55/3
165/12 166/18 170/4	Sir [1] 178/17	47/18 48/4 48/9 50/15	132/19 190/23 194/23	115/12
171/13 176/22 177/16	Sir Chris Whitty [1]	53/7 55/8 57/12 58/24	sorting [1] 136/25	spring/summer [1]
178/20 178/23 180/11	178/17	59/3 60/19 61/11 63/9	sorts [1] 96/4	115/12
182/25 183/8 188/12	sites [6] 33/9 116/12	68/10 69/19 75/24	sought [1] 41/9	St [1] 175/11
189/2 190/1 191/18	128/1 128/7 128/10	76/6 76/19 77/8 77/22	sounds [1] 150/21	staff [72] 3/10 3/10
194/13 195/3	130/7	77/23 78/2 81/1 85/21	south [1] 21/2	4/21 14/24 15/6 15/13
shoulders [1] 47/3	sitting [3] 173/19	86/7 87/16 87/17	south-east [1] 21/2	15/15 15/17 19/17
shouldn't [2] 24/25	179/23 190/22	88/14 89/15 94/2 94/3	sovereignty [1]	20/10 22/11 25/7 26/7
	situation [10] 3/8	94/5 94/5 96/22 99/18	120/3	26/18 26/19 27/11

S	124/11 126/8 135/2 138/11 140/11 141/5 146/18 154/19 155/13 162/17 164/4 164/15 169/4 174/5 176/11 183/17 183/24 193/7 195/23 201/3 statements [1] 53/12 states [1] 116/11 statistics [1] 178/13 statutory [5] 2/13 93/17 93/19 125/18 154/11 stay [1] 95/21 step [6] 32/1 32/1 33/7 33/11 33/21 37/19 step down [1] 33/11 stepping [1] 173/5 steps [19] 64/19 67/18 71/2 71/11 76/23 79/9 94/16 96/6 115/9 117/9 139/6 147/1 148/20 150/22 152/22 161/14 186/24 193/9 202/24 sticks [1] 71/23 still [40] 3/11 11/24 16/1 23/17 25/24 33/15 37/11 44/18 44/19 49/13 50/19 51/17 56/11 76/22 77/9 82/18 84/12 89/2 93/21 94/3 94/12 100/10 102/7 104/2 107/1 107/5 109/16 110/17 119/20 121/6 123/10 123/18 128/6 129/8 146/2 156/18 160/5 184/17 198/8 203/12 stock [17] 22/10 34/11 34/14 34/17 36/24 38/12 39/5 40/2 40/6 40/8 41/4 42/18 45/9 46/19 89/2 89/5 89/18 stockpile [8] 37/20 37/21 38/25 39/14 83/12 85/5 88/11 88/14 stocks [5] 34/22 35/24 36/24 37/10 37/13 stood [1] 91/17 stop [5] 54/2 107/14 107/20 139/17 158/17 stopped [6] 40/11 142/7 160/15 190/4 190/8 200/16 stopping [2] 86/17 86/25 store [1] 79/17 story [1] 109/23	straight [1] 145/13 straightforward [3] 92/1 166/23 180/23 strain [2] 19/10 103/25 strategic [8] 4/13 31/13 31/14 50/9 124/18 159/2 180/22 186/15 strategies [1] 141/12 strategy [6] 2/10 8/9 12/19 31/14 100/15 150/4 strengthened [1] 103/20 stress [3] 15/7 79/7 103/25 stretch [1] 28/12 stretched [6] 25/16 25/19 27/24 28/16 131/6 202/20 strict [1] 139/9 strike [2] 25/4 82/11 stronger [1] 8/4 struck [5] 81/12 82/8 117/8 143/21 143/25 structural [1] 100/13 structure [3] 42/17 187/9 187/12 structures [4] 6/20 7/19 159/5 159/6 students [1] 195/11 study [5] 60/23 110/1 159/19 159/21 200/4 stuff [2] 40/25 90/15 subgroup [4] 74/14 74/21 76/11 99/7 subgroup's [2] 100/12 101/5 subgroups [1] 102/20 subject [1] 198/18 submit [1] 157/5 substantial [2] 10/6 74/10 successfully [1] 138/20 successor [1] 97/25 such [6] 81/21 124/7 154/21 171/1 193/1 204/9 suddenly [1] 91/1 suffered [2] 109/14 180/17 suffering [7] 49/13 50/15 52/18 155/6 156/4 160/6 170/19 sufficient [7] 3/16 19/25 22/21 46/15 47/7 115/10 116/21 sufficiently [1] 8/9 sugar [1] 69/2 suggest [1] 166/25 suggested [6] 7/23	18/22 29/15 30/5 36/18 167/3 suggesting [2] 32/1 80/14 suggestion [3] 82/15 97/12 163/11 suggests [3] 31/6 53/23 64/10 suitable [1] 167/8 summarised [1] 157/8 summary [1] 29/5 summer [4] 73/5 115/12 152/13 183/19 Sunday [1] 184/21 supplement [1] 194/23 supplies [3] 38/25 90/7 90/9 supply [17] 34/17 35/18 35/19 37/8 38/1 39/10 39/20 39/25 40/6 45/3 58/24 73/24 88/13 89/6 91/19 91/25 92/5 supplying [1] 38/23 support [36] 26/17 32/5 48/23 49/11 51/10 53/16 53/17 55/6 81/19 94/12 95/2 95/21 97/21 132/2 139/11 143/11 143/11 152/25 155/19 156/7 159/7 159/11 159/17 169/11 169/13 170/16 171/7 172/16 175/8 175/24 176/1 176/2 176/5 177/15 188/1 188/11 supported [1] 73/21 supporter [1] 186/7 supporters [1] 143/23 supporting [5] 57/9 142/14 169/25 175/22 175/23 supports [1] 117/16 suppose [1] 62/6 supposed [2] 34/17 68/2 sure [75] 4/10 9/1 10/24 13/22 14/1 22/4 24/6 25/7 26/3 28/8 31/9 40/8 44/24 46/3 46/12 50/1 53/14 53/14 58/25 61/21 63/5 65/24 67/25 81/25 84/11 85/11 90/14 97/19 100/1 101/22 102/6 103/4 104/4 105/24 111/9 120/15 123/15 123/17 131/23 136/20 137/16 137/18 139/10 139/18	141/22 148/23 153/23 157/19 158/9 159/8 161/6 162/9 163/6 163/8 163/18 165/12 165/13 165/15 165/16 167/5 168/19 177/15 178/5 180/15 189/12 190/12 191/18 192/7 197/4 199/24 200/1 200/12 202/10 202/14 202/21 surge [8] 19/9 19/11 21/13 24/19 111/25 131/6 131/9 132/17 surgeons [4] 6/15 12/11 149/11 150/12 surgeries [2] 160/25 161/15 surgery [5] 9/12 9/19 148/5 170/9 181/10 surges [1] 131/9 surgical [3] 11/6 35/15 147/20 surprise [5] 25/1 68/3 75/14 120/21 202/18 surprised [5] 104/18 113/22 114/4 136/23 160/9 surprising [1] 75/17 surrounded [1] 133/11 surveillance [2] 201/5 201/10 survey [4] 79/4 79/14 159/21 198/25 suspect [1] 24/11 suspend [1] 9/10 suspending [1] 18/1 suspension [1] 16/14 Swansea [1] 63/25 Swansea Bay [1] 63/25 switch [4] 76/25 123/12 158/6 173/13 sworn [2] 122/5 205/14 sympathetic [1] 81/8 symptomatic [1] 58/11 symptoms [4] 41/19 54/5 105/23 106/8 system [70] 8/11 13/19 14/21 15/19 15/22 18/19 19/13 20/10 21/22 21/23 26/5 26/5 28/25 29/7 29/9 33/18 33/25 36/18 40/11 43/2 44/15 48/16 49/18 49/20 55/18 65/25 85/11 98/3 100/22 106/1 107/16 108/15 108/16 108/18 109/1
----------	---	--	---	---

S	121/16 142/18 187/15 194/1 talk [4] 10/8 74/4 103/13 103/13 talked [3] 31/17 90/20 189/6 talking [6] 13/15 22/7 30/18 62/16 62/17 168/21 talks [2] 49/19 101/14 target [3] 58/7 58/19 168/3 targeted [1] 99/10 targets [1] 58/12 Taskforce [1] 168/1 tasks [1] 171/1 taxi [3] 77/25 101/17 101/23 teacher [1] 78/2 team [4] 11/6 30/10 47/1 158/17 teams [2] 158/7 159/10 tech [1] 113/8 Technical [1] 7/2 technology [2] 7/12 112/23 telephone [3] 84/14 161/3 162/7 tell [15] 21/14 21/18 28/4 43/5 52/21 59/9 72/25 74/2 78/22 109/23 120/9 121/2 134/5 190/7 204/9 telling [2] 3/2 11/8 tens [1] 85/14 tenure [3] 15/19 24/16 151/12 term [9] 47/22 47/24 48/9 48/12 48/25 51/5 51/17 118/3 118/20 terms [42] 3/8 28/5 34/23 54/11 73/3 83/6 89/25 98/8 114/13 118/16 118/16 119/7 124/12 126/3 127/13 130/1 132/6 137/15 137/18 137/24 139/9 146/17 149/6 150/1 150/13 151/21 152/20 155/2 155/9 156/7 157/15 158/3 161/19 172/25 174/3 176/9 177/13 179/16 179/19 188/21 190/25 193/25 test [5] 46/3 46/10 64/15 67/4 123/17 tested [3] 114/12 135/20 202/14 testing [33] 4/3 13/2 35/7 35/8 35/9 40/19 58/1 58/10 58/19 59/10 59/13 65/3 65/3	65/6 65/6 67/4 69/21 69/25 70/11 71/20 82/4 82/16 112/13 112/15 113/3 114/7 115/6 115/10 115/11 115/18 115/23 115/24 202/11 tests [9] 45/25 46/7 47/15 58/5 58/8 58/9 85/4 113/13 114/10 than [62] 8/18 9/8 10/5 14/15 15/14 17/8 19/19 20/8 20/17 22/2 24/9 24/11 28/2 28/2 34/5 34/19 35/7 35/15 49/24 53/20 54/1 66/19 69/4 71/9 75/12 77/11 78/1 87/11 87/14 87/15 89/3 90/20 95/17 100/11 108/3 118/1 123/6 128/17 128/22 136/15 138/2 138/17 139/23 144/17 147/22 148/13 149/8 150/6 152/14 155/23 164/1 165/3 171/12 171/20 172/3 172/10 174/8 177/7 192/22 193/4 198/4 200/16 than June [1] 155/23 thank [56] 1/7 1/10 57/18 57/23 57/25 92/7 92/8 95/19 96/16 96/17 98/21 98/22 98/23 104/21 104/22 104/23 105/4 108/7 108/8 108/9 112/13 121/12 121/13 121/14 121/20 121/21 122/9 126/8 127/19 132/19 143/18 164/3 167/7 175/14 182/11 183/15 184/12 184/25 185/1 186/17 187/16 187/17 187/20 189/14 190/13 190/14 191/11 197/5 197/6 197/18 198/11 204/2 204/3 204/4 204/10 204/11 Thanks [1] 188/20 that [1393] that clinical [1] 54/16 that has [1] 111/17 that's [91] 1/25 2/7 3/8 5/12 10/23 11/9 11/11 15/21 15/23 19/20 21/4 21/25 22/15 23/5 23/15 27/13 27/20 28/8 29/9 30/8 30/8 30/22 33/17 34/17 36/8 36/21 39/9 45/9 45/21 47/4 48/20 48/20 53/8 53/18 55/9	55/11 62/16 64/8 65/13 65/19 73/21 76/6 76/21 79/25 83/8 86/18 88/3 93/20 95/5 98/10 99/19 105/24 109/2 109/17 110/9 113/13 114/14 116/3 116/24 118/17 119/1 121/8 122/16 122/20 122/25 125/15 126/19 126/24 128/20 131/13 134/24 147/14 151/13 159/3 167/7 167/8 167/22 168/22 179/13 180/6 181/15 181/19 181/19 181/23 189/14 191/8 193/4 195/5 196/8 197/24 198/7 theatre [2] 33/15 33/16 their [70] 3/9 4/21 4/25 5/1 9/14 9/21 15/11 22/8 25/23 30/23 43/16 43/20 44/1 45/20 50/21 55/19 56/6 64/16 68/21 69/11 70/1 78/19 78/24 80/24 81/13 83/22 84/1 84/12 88/1 91/18 93/8 94/5 94/13 95/25 97/6 97/13 101/25 102/8 108/21 108/22 120/17 124/16 129/4 136/8 140/10 143/12 146/8 148/6 152/1 152/18 153/7 158/13 158/23 160/3 160/14 162/20 165/3 165/18 166/19 174/12 177/7 178/15 182/20 183/1 183/5 184/7 185/8 192/2 192/13 194/16 them [78] 2/3 10/17 10/20 11/7 11/8 11/22 16/10 19/9 20/11 20/15 21/18 26/20 33/11 36/17 37/16 38/11 38/15 40/17 43/4 48/4 50/14 53/15 56/5 57/9 66/11 72/20 79/20 83/4 83/16 85/18 85/18 94/3 94/4 94/5 94/5 95/15 95/21 96/1 101/25 125/23 126/2 128/16 133/11 142/6 151/25 152/10 152/10 152/15 152/15 152/20 153/1 153/2 153/3 153/5 154/2 154/17 155/2 155/7 161/17 173/11 173/13 173/14 173/19 174/14 174/23 175/24 179/18	180/20 180/21 182/4 182/4 182/5 183/6 183/10 186/8 187/1 191/17 196/20 thematic [1] 165/21 theme [1] 185/10 themselves [10] 53/16 66/3 78/18 85/17 117/18 140/8 154/18 161/18 161/24 191/13 then [111] 3/7 5/15 10/5 11/18 12/5 12/25 13/10 14/14 14/17 15/23 18/7 19/12 21/1 23/5 27/18 32/4 32/9 32/9 32/10 32/24 32/25 33/3 33/4 33/5 34/23 35/11 35/17 36/23 36/24 37/2 37/6 37/14 40/6 40/7 42/3 42/8 42/11 42/17 45/2 45/5 46/14 48/5 50/1 50/6 51/21 52/2 52/8 55/18 56/1 56/5 60/13 62/14 62/18 63/23 68/4 68/24 70/12 71/10 73/2 73/22 77/1 77/20 79/15 80/17 81/25 82/12 83/6 87/6 88/9 89/8 93/11 93/21 95/7 99/19 99/23 101/21 102/2 104/13 107/23 108/25 110/21 113/12 116/7 117/15 117/15 124/4 125/16 126/6 132/19 135/22 136/5 136/10 139/17 141/21 142/8 142/24 151/7 155/10 159/10 161/10 165/19 167/2 177/2 178/24 181/11 184/3 189/1 200/11 201/15 203/5 203/19 therapies [1] 110/12 therapist [5] 48/14 48/22 49/4 54/19 55/6 therapists [2] 45/13 156/22 therapy [2] 55/7 106/9 there [292] there'll [2] 13/7 66/14 there's [49] 19/3 19/13 28/7 28/20 28/22 36/22 38/8 46/20 52/13 54/7 56/13 60/23 62/15 69/2 70/23 76/7 77/12 81/24 82/21 87/8 87/14 88/25 90/7 98/11 110/14 117/20 126/7 134/12 135/22 136/5 136/10 146/4
----------	---	--	--	---

T	173/18 174/1 179/15 179/21 180/24 180/25 181/11 184/10 191/5 191/7 192/5 192/20 193/3 193/6 199/14 203/20	those days [1] 24/11 though [11] 20/19 22/20 24/20 26/11 27/24 56/19 75/16 113/12 120/22 121/5 181/15 thought [28] 8/3 9/20 14/9 16/19 20/4 20/7 30/22 33/11 34/16 39/2 39/11 40/14 53/8 58/10 58/23 73/4 89/2 95/16 139/14 142/9 154/16 156/5 160/18 168/20 183/12 194/14 196/21 198/1 thousand [1] 11/20 thousands [1] 85/14 threatening [1] 168/4 three [6] 11/6 21/2 32/23 43/4 80/5 176/19 through [54] 2/3 5/11 5/13 10/6 22/19 23/18 24/3 27/2 27/2 27/3 32/12 33/7 34/18 34/22 38/15 39/11 40/13 40/14 46/23 49/14 50/4 50/10 52/21 53/1 55/3 71/1 71/25 73/14 76/19 78/18 79/25 80/1 80/19 84/22 90/3 90/24 114/16 115/20 120/17 124/2 125/24 125/24 134/23 142/3 145/15 145/21 146/9 173/21 173/23 174/12 175/24 178/8 184/19 194/15 through December [1] 114/16 through the [1] 90/24 throughout [8] 5/20 34/20 44/3 66/4 70/6 167/18 173/7 189/3 Thursday [2] 149/10 204/16 tide [1] 114/15 tie [2] 61/22 61/25 tighten [2] 140/19 142/4 tightened [2] 126/6 142/7 tightening [1] 185/25 till [1] 52/25 time [100] 3/12 4/12 4/25 5/15 13/4 19/16 22/7 23/11 29/4 31/21 35/8 35/9 36/21 39/2 39/18 39/19 42/24 47/6 48/18 51/5 53/12 56/17 58/10 60/1 63/2 65/2 67/5 68/3 70/1 71/16 72/9 72/15	73/17 74/6 74/10 77/8 77/12 78/15 79/25 82/9 83/21 84/2 89/7 89/10 89/12 90/17 90/24 92/19 92/24 93/8 93/12 96/9 102/19 111/22 112/3 113/6 114/15 118/16 118/17 121/15 124/20 125/14 129/6 129/20 131/8 131/9 132/4 135/5 135/10 141/18 143/7 143/16 144/10 144/18 145/3 145/8 153/20 153/23 155/14 157/20 158/1 161/2 161/8 163/16 167/16 168/21 168/21 173/4 173/20 173/21 178/2 180/12 183/9 184/7 184/9 195/12 196/12 199/18 201/20 202/12 timely [1] 114/8 times [21] 8/25 9/14 11/14 15/6 23/3 28/3 43/4 45/17 66/6 70/13 103/7 109/10 115/21 142/11 146/20 167/18 168/18 182/6 186/3 202/22 202/22 timing [1] 167/9 tips [2] 153/2 153/3 today [10] 1/4 50/19 50/20 109/8 121/17 122/7 123/1 129/7 160/6 186/20 today's [1] 63/16 together [12] 40/16 62/3 70/2 70/9 82/20 91/10 156/22 158/8 179/9 179/18 179/20 182/25 told [18] 2/20 19/5 19/21 29/18 37/20 38/1 43/24 66/8 66/11 72/12 72/20 78/25 130/2 130/4 148/10 158/15 166/11 178/17 tomorrow [1] 204/13 too [9] 25/17 37/8 62/7 69/23 74/7 128/13 159/25 184/8 184/8 took [29] 6/17 15/21 31/8 32/22 43/10 44/10 55/2 61/10 61/18 71/22 77/16 77/22 92/17 94/7 96/12 102/8 102/22 137/19 147/1 150/22 163/21 163/24 163/25 167/15 184/8 184/8 185/19 187/11 199/1 tool [14] 76/1 77/21	99/15 99/20 100/4 102/1 102/5 102/22 176/15 177/1 177/8 177/17 193/20 196/1 tools [1] 116/2 top [3] 9/17 39/16 62/13 top-down [1] 9/17 topic [14] 34/2 69/6 83/17 88/4 116/7 126/17 134/24 144/11 162/12 167/8 187/25 200/22 203/5 203/19 topics [5] 1/14 47/19 71/25 80/5 86/6 Total [1] 129/21 touched [5] 88/5 88/20 96/24 102/9 176/4 tough [1] 145/14 towards [3] 5/15 95/22 184/5 Trace [2] 67/4 123/17 track [3] 16/19 186/9 186/11 tracking [2] 90/8 178/19 trade [9] 3/25 4/1 4/7 36/13 42/21 45/10 56/12 66/18 80/4 trail [2] 42/1 42/15 train [1] 173/14 training [2] 20/18 166/5 tranche [1] 172/8 transcript [1] 148/6 transcripts [1] 158/13 transfer [2] 27/18 169/12 transferred [1] 26/22 transfers [5] 27/3 27/5 27/8 147/15 173/19 transformation [3] 8/15 10/14 181/17 transient [1] 48/1 transition [2] 65/12 73/13 transmissibility [1] 68/15 transmissible [3] 68/5 68/10 140/13 transmission [33] 59/14 59/17 60/4 60/9 60/14 60/25 61/7 61/9 62/14 63/6 63/13 63/18 64/11 64/12 64/13 67/14 67/20 67/23 68/3 68/18 69/8 69/14 82/7 136/7 136/18 136/22 137/12 138/22 139/7 140/14 141/1 141/8 142/15
----------	--	--	---	--

T	TUC [3] 43/14 45/16 60/2	148/25 176/6 177/10 182/7 184/16 186/11 202/21	80/4	187/6 197/25 199/11 200/12 200/15 201/5 201/15
transmissions [2] 65/22 142/18	tuck [1] 61/22	Turkey [1] 90/11	unions [9] 4/1 4/1 4/7 36/14 42/21 45/11 45/12 66/18 110/13	update [4] 51/4 110/23 127/21 127/22
transport [1] 16/16	turn [11] 14/2 15/24 20/24 22/9 25/10 58/1 85/21 133/1 133/6 201/8 203/8	turned [3] 17/19 37/25 175/25	UNISON [2] 4/21 45/11	updated [2] 50/22 70/2
traumatised [1] 134/23	turning [2] 111/7 175/15	under [1] 18/10	unit [5] 26/9 40/10 83/4 83/5 183/6	updates [6] 23/20 23/24 23/25 42/18 113/3 132/13
travel [2] 49/21 49/25	twice [1] 51/20	underplay [1] 53/20	Unite [2] 4/21 45/11	updating [1] 157/23
treat [2] 52/10 183/6	two [26] 9/15 23/2 23/22 32/23 39/25 43/4 51/22 52/3 77/1 86/5 87/10 91/9 97/22 98/6 111/23 112/17 113/11 131/3 133/21 138/12 147/19 148/4 151/14 156/23 158/11 189/23	underplays [1] 17/1	United [3] 166/22 180/5 199/25	upfront [1] 41/5
treated [2] 45/18 184/2	two days' [1] 39/25	understand [40] 2/19 5/14 11/15 13/4 13/7 14/6 14/25 14/25 22/20 22/22 24/20 27/15 29/1 34/5 38/5 47/10 50/13 52/7 55/17 55/21 56/7 56/9 57/6 57/7 57/7 57/8 61/4 76/23 79/15 79/23 98/7 103/6 106/22 110/3 110/17 116/25 117/3 128/15 134/9 144/15	United Kingdom [3] 166/22 180/5 199/25	upon [4] 52/9 88/21 102/9 179/10
treatment [15] 11/16 50/12 69/11 70/5 83/23 102/16 106/6 109/2 111/21 112/1 144/16 145/17 148/16 159/25 195/22	two weeks [5] 23/22 77/1 87/10 112/17 113/11	understanding [37] 3/16 3/19 11/10 13/3 34/10 35/3 35/8 35/18 38/13 39/20 40/12 40/18 42/11 47/25 48/6 50/2 50/7 55/16 59/25 67/10 68/17 75/22 77/4 79/15 83/3 84/11 99/16 102/24 109/14 111/13 112/5 114/17 146/5 149/3 161/6 175/17 201/9	units [2] 26/23 131/7	upsetting [1] 30/8
treatments [1] 196/5	two years [1] 9/15	understands [3] 68/9 107/9 109/18	University [3] 26/13 27/25 118/4	urge [1] 10/17
triaged [1] 196/12	type [3] 28/18 28/20 47/13	understood [11] 22/8 26/10 27/19 36/1 60/19 69/15 75/10 84/16 113/5 141/23 198/9	Unlike [1] 26/23	urged [1] 12/11
triaging [1] 161/19	types [3] 40/18 47/7 47/24	undertake [2] 12/12 199/7	unnecessary [2] 105/17 105/18	urgency [1] 34/19
triangulation [1] 127/6	tyres [1] 126/23	undertaken [7] 65/5 106/4 117/12 179/7 180/8 198/23 199/1	unoccupied [1] 130/20	urgent [7] 9/7 9/10 10/22 16/14 118/20 128/19 144/20
tried [7] 15/22 40/9 77/2 84/21 105/25 178/5 200/8	U	undertaking [2] 60/16 134/1	unplanned [1] 149/9	us [51] 1/11 2/20 3/1 4/16 7/8 8/1 19/18 19/21 20/22 22/2 38/1 43/24 44/23 57/7 57/15 58/15 62/5 66/8 66/18 79/1 86/14 89/9 90/11 94/8 97/4 99/22 103/13 117/3 117/5 117/17 118/6 121/17 125/3 128/24 130/16 149/5 150/9 154/17 163/20 166/20 181/4 181/16 184/12 185/25 188/16 193/5 193/24 196/16 199/18 199/20 204/9
tries [1] 59/15	UHW [2] 11/3 21/8	undertaken [7] 65/5 106/4 117/12 179/7 180/8 198/23 199/1	unprecedented [1] 199/15	usable [1] 90/15
trigger [1] 196/19	UK [32] 34/16 39/22 45/4 79/6 86/4 86/21 86/24 87/3 87/17 87/21 87/25 90/12 91/6 91/11 91/14 91/15 91/16 91/20 92/3 93/20 112/16 112/20 134/8 166/7 166/14 166/16 185/7 187/23 194/5 194/8 195/6 198/20	undertakes [3] 68/9 107/9 109/18	unrestricted [1] 183/5	usage [1] 34/23
triggered [1] 164/16	UK-wide [1] 195/6	understands [3] 68/9 107/9 109/18	unscrupulous [1] 40/22	use [23] 2/10 32/2 34/25 43/20 44/14 46/13 58/9 72/18 102/6 117/18 125/20 139/18 146/10 146/11 146/11 166/14 169/14 175/7 175/11 177/8 194/7 195/9 203/23
triple [1] 21/18	unacceptable [2] 83/7 113/21	understood [11] 22/8 26/10 27/19 36/1 60/19 69/15 75/10 84/16 113/5 141/23 198/9	until [17] 1/24 52/16 60/13 60/22 63/19 72/6 86/14 89/3 113/18 115/11 116/3 146/23 157/11 158/5 172/19 183/25 204/15	used [26] 32/17 32/21 32/24 33/3 33/23 37/5 41/1 44/7 64/10 64/22 65/8 82/17 88/13 89/19 101/10 107/25 111/17 112/23 129/2 132/25 133/1 146/7 159/14 166/8 175/8 201/10
trouble [2] 35/11 121/16	unannounced [1] 133/1	undertake [2] 12/12 199/7	until December [1] 157/11	useful [9] 118/10 130/6 130/8 131/10 133/14 179/6 179/24 191/14 193/20
true [4] 25/10 142/23 142/24 198/8	unavoidable [2] 30/25 118/18	undertaken [7] 65/5 106/4 117/12 179/7 180/8 198/23 199/1	until May 2022 [1] 183/25	users [3] 140/3 159/23 159/24
truly [1] 187/14	unaware [1] 21/24	undertaking [2] 60/16 134/1	unusual [2] 43/10 98/2	using [5] 4/25 16/15 33/11 129/1 145/19
trust [17] 4/15 5/4 5/9 43/5 87/13 91/14 92/4 104/4 168/12 169/17 169/22 170/4 172/5 172/16 176/17 184/4 184/4	uncertain [1] 48/4	undertakes [3] 68/9 107/9 109/18	unwell [1] 28/25	
trusted [1] 91/24	unclear [2] 43/13 44/24	understands [3] 68/9 107/9 109/18	up [80] 4/4 12/13 20/21 22/3 22/8 22/8 28/24 32/1 34/13 35/2 38/21 39/18 41/12 41/23 44/8 44/18 46/18 51/1 52/2 52/8 53/9 53/25 54/3 55/19 56/1 57/13 60/13 61/10 62/9 62/19 62/21 71/16 74/18 80/3 82/4 85/15 89/25 90/24 91/17 92/15 104/14 114/6 114/19 120/2 123/13 126/6 126/20 126/21 133/1 133/6 133/7 133/21 133/22 138/15 139/2 139/20 140/19 142/5 142/7 142/8 148/23 152/12 157/21 157/25 161/18 163/7 166/2 173/2 173/5 173/14 181/12 182/14 185/25	
trusts [7] 9/18 56/25 78/18 120/3 120/5 124/15 176/19	undeniable [1] 19/20	understood [11] 22/8 26/10 27/19 36/1 60/19 69/15 75/10 84/16 113/5 141/23 198/9	up [80] 4/4 12/13 20/21 22/3 22/8 22/8 28/24 32/1 34/13 35/2 38/21 39/18 41/12 41/23 44/8 44/18 46/18 51/1 52/2 52/8 53/9 53/25 54/3 55/19 56/1 57/13 60/13 61/10 62/9 62/19 62/21 71/16 74/18 80/3 82/4 85/15 89/25 90/24 91/17 92/15 104/14 114/6 114/19 120/2 123/13 126/6 126/20 126/21 133/1 133/6 133/7 133/21 133/22 138/15 139/2 139/20 140/19 142/5 142/7 142/8 148/23 152/12 157/21 157/25 161/18 163/7 166/2 173/2 173/5 173/14 181/12 182/14 185/25	
truth [2] 23/8 118/18	under [17] 11/13 15/7 19/9 65/16 103/25 111/14 129/21 133/24 134/5 136/1	undertake [2] 12/12 199/7	unwell [1] 28/25	
try [34] 12/8 12/11 12/12 12/22 13/7 16/18 20/9 22/20 30/3 31/9 62/3 64/20 65/24 67/19 68/14 70/17 75/25 79/9 79/15 87/1 102/6 103/16 106/6 106/7 107/24 110/17 119/13 124/8 139/6 141/12 159/6 166/25 186/24 200/12	under [17] 11/13 15/7 19/9 65/16 103/25 111/14 129/21 133/24 134/5 136/1	undertaken [7] 65/5 106/4 117/12 179/7 180/8 198/23 199/1	unwell [1] 28/25	
trying [20] 12/10 20/22 23/19 40/20 54/13 69/4 76/3 106/25 121/2 128/13 130/11 136/17 136/21 137/16 140/25 156/18 179/13 181/4 184/18 189/24		undertaking [2] 60/16 134/1	unwell [1] 28/25	

U
usual [3] 17/20 26/16
161/1
usually [1] 127/7
utility [1] 35/8

V
vaccinated [2] 152/8
152/21
vaccination [8] 2/5
33/5 102/24 102/25
103/15 123/11 125/12
153/12
vaccine [4] 103/2
153/25 154/7 154/7
vaccines [1] 92/20
vague [1] 148/13
vaguely [1] 193/18
Vale [3] 12/7 21/3
27/17
value [4] 36/3 57/11
58/10 85/18
valued [3] 79/16
79/19 79/21
values [1] 136/11
variability [1] 100/14
variant [6] 68/5 68/9
140/12 140/14 153/11
153/19
variants [1] 53/4
variation [1] 158/19
variations [1] 141/13
varied [1] 18/21
variety [2] 46/15 47/7
various [10] 1/16
27/23 78/14 99/8
102/19 118/16 121/1
124/11 147/6 179/14
vary [1] 136/11
vast [1] 19/25
Vaughan [3] 1/5 1/8
205/3
vehicles [2] 169/12
174/17
veil [1] 42/10
Velindre [1] 176/16
ventilation [24] 14/14
31/5 70/15 70/16
70/20 70/24 71/3 96/3
108/25 117/7 137/20
139/12 190/25 191/7
191/10 191/13 192/18
193/1 194/5 194/23
194/24 203/8 203/9
203/12
ventilator [1] 15/3
verse [1] 66/15
very [94] 10/10 13/8
14/16 18/5 18/6 18/15
18/18 26/17 26/22
30/1 30/8 30/12 36/8
41/2 41/14 41/17
41/21 52/22 54/4 54/5

67/9 67/9 81/8 82/6
86/8 92/7 96/12
100/19 105/7 108/9
121/13 121/14 121/23
123/10 123/12 123/14
124/6 125/12 126/3
126/25 130/23 130/23
139/9 139/14 139/15
144/19 147/21 149/20
149/20 156/25 158/25
159/2 159/13 160/21
160/25 162/3 163/12
163/17 164/20 167/7
171/7 171/8 172/4
176/4 178/3 178/6
179/19 180/22 182/5
182/11 182/19 182/21
183/18 184/17 184/18
184/19 184/19 184/25
185/1 186/12 186/14
187/16 189/14 195/10
196/17 197/3 197/4
197/11 200/14 202/12
204/3 204/4 204/10
204/13
veto [1] 107/1
via [6] 1/5 79/1 159/8
159/9 194/8 200/24
vice [1] 6/6
video [1] 1/5
video link [1] 1/5
view [7] 68/11 87/4
108/4 110/19 133/8
180/10 182/24
views [11] 79/1 91/18
126/19 154/25 155/1
166/19 182/22 186/22
186/24 186/25 187/10
virus [7] 47/22 93/1
96/2 96/3 152/21
153/7 154/4
visceral [1] 30/12
visible [1] 127/25
visit [6] 43/3 61/21
74/11 133/18 141/23
156/19
visited [3] 150/14
156/22 176/3
visiting [21] 81/7
81/9 81/12 82/3 97/7
137/21 139/9 140/25
141/3 141/7 141/15
142/8 142/17 143/4
143/6 143/19 143/24
182/20 182/22 185/13
185/25
visitor [4] 143/9
185/12 186/8 187/2
visitors [6] 142/16
143/11 143/15 143/23
184/2 185/19
visits [5] 81/13 81/14
81/17 133/1 149/10
visors [2] 43/17

44/21
vital [1] 178/18
voice [2] 98/5 150/19
volumes [1] 35/3
volunteers [1] 73/22
vulnerability [1]
19/19
vulnerable [29] 11/7
11/8 16/17 69/9 69/10
69/14 73/1 74/7 92/13
92/21 92/22 93/2
95/24 95/25 96/11
140/1 140/5 151/25
152/19 153/13 155/2
155/9 180/18 190/20
192/2 192/13 193/21
196/7 196/18

W
Waddoup [7] 96/18
96/19 182/14 182/16
185/11 205/9 205/17
Wagner [12] 92/9
92/10 92/12 93/6
96/17 190/15 190/16
190/17 190/19 197/6
205/8 205/21
waiters [1] 149/24
waiting [12] 9/7 9/14
133/2 133/3 145/15
146/8 146/20 146/24
147/8 149/22 149/22
174/20
Wales [170] 2/13 6/7
7/21 7/24 8/13 9/14
9/18 15/4 15/20 17/8
17/9 17/11 17/11
17/11 17/25 18/5
18/14 18/23 18/25
19/8 21/23 23/4 24/15
25/2 25/12 26/6 26/14
27/13 27/25 29/12
30/11 31/10 32/1
33/10 35/21 39/25
40/16 45/18 49/11
49/16 49/19 51/6
51/23 52/4 52/6 52/17
53/9 53/22 54/15 58/4
58/15 58/21 59/2
59/16 61/4 64/2 64/8
66/9 68/6 69/22 70/14
71/3 71/8 72/4 74/13
74/25 78/13 78/17
85/4 86/5 86/13 86/22
86/25 87/12 88/10
91/4 91/6 92/2 102/4
106/17 107/3 107/15
107/21 108/6 110/2
110/9 110/23 111/20
112/18 112/21 112/24
114/24 115/4 116/11
116/17 117/7 117/11
119/4 120/1 122/14
124/13 125/2 128/2

131/9 133/15 135/11
136/4 137/18 139/12
139/20 140/12 141/10
143/13 144/21 145/4
146/6 146/7 146/14
146/20 148/8 148/16
151/9 151/15 153/15
155/16 156/8 156/9
157/13 158/19 158/21
159/2 159/6 159/23
161/5 161/11 161/15
162/22 163/2 163/15
163/21 164/17 165/10
172/7 175/9 176/14
178/12 178/16 179/3
180/8 181/4 181/8
183/3 187/7 187/24
188/3 188/10 188/12
188/17 189/3 189/10
194/2 194/15 196/15
198/3 198/23 199/2
199/13 201/4 202/9
203/1
Wales' [1] 26/23
Walker [1] 11/2
want [26] 9/3 10/24
17/24 28/10 35/12
42/7 42/10 49/19
54/13 56/5 56/6 57/6
65/14 66/12 85/8
92/14 95/15 98/12
99/22 125/23 147/12
152/16 177/3 190/20
193/16 195/18
wanted [10] 9/2
22/20 27/17 36/11
40/22 94/10 105/11
150/13 152/14 177/14
wanting [6] 6/16
19/13 46/11 53/20
55/17 74/6
wants [1] 11/13
ward [5] 83/2 130/19
140/8 183/2 183/6
wards [6] 41/19
139/15 139/16 139/16
139/24 140/10
was [674]
was: [1] 47/4
was: well [1] 47/4
washing [1] 119/16
wasn't [36] 15/2
21/24 33/3 47/3 48/18
52/16 60/12 60/22
67/2 80/15 94/11
100/6 106/19 107/3
113/11 116/20 118/11
128/13 136/19 145/3
145/24 147/4 150/1
150/22 150/24 151/11
152/17 156/20 160/23
164/25 164/25 178/8
183/24 184/23 193/22
202/22

WAST [1] 171/13
watching [1] 7/7
wave [38] 9/24 10/5
26/17 26/20 27/6
32/10 32/12 32/23
33/4 33/7 33/13 34/20
44/4 44/4 44/6 44/12
44/25 45/2 45/17
47/11 53/2 67/18
67/19 69/16 73/7 78/9
123/4 131/22 138/17
138/17 138/19 138/23
139/4 142/6 143/2
173/7 203/11 203/13
wave 1 [4] 44/25 45/2
45/17 67/18
wave 2 [1] 67/19
wave' [1] 135/18
waves [7] 16/2 26/15
44/3 129/14 142/3
179/14 185/23
waves 1 [1] 44/3
way [56] 6/17 7/5
13/20 14/2 14/16
14/22 20/23 21/9 22/7
26/8 28/17 49/9 49/17
49/18 49/19 50/18
54/4 54/10 56/4 58/14
67/4 70/22 73/9 82/1
83/4 85/17 87/16 89/6
100/21 100/24 102/18
103/13 104/5 104/6
109/17 116/3 117/13
119/15 126/3 137/3
146/14 149/13 149/18
150/2 152/17 158/25
161/1 164/9 166/25
167/1 176/7 181/13
181/22 182/15 184/19
186/10
ways [1] 134/12
we [497]
we won't [1] 121/18
we'd [28] 14/9 14/23
15/22 32/1 32/23 33/2
40/10 40/14 44/9
44/14 52/5 53/4 58/23
65/8 69/18 69/25 72/9
72/10 72/12 72/21
72/22 78/7 89/14
89/17 95/8 113/5
117/12 142/20
we'll [6] 15/17 25/7
31/18 120/7 121/19
180/6
we're [25] 13/15
16/18 19/5 22/24
23/21 27/9 27/9 27/10
32/12 72/22 77/11
78/5 85/21 95/5
101/21 103/11 103/12
111/3 111/3 119/11
157/19 162/3 166/22
182/21 197/11

W	132/9 136/19 137/13 138/24 139/9 140/7 144/5 144/19 145/8 145/23 146/12 147/4 149/20 152/8 154/3 155/4 158/2 158/25 160/2 161/9 167/2 172/8 172/24 173/9 173/9 174/4 175/11 175/18 179/12 179/25 182/3 185/21 188/20 189/5 190/25 191/13 192/4 193/24 200/7 203/2 203/14 204/13	53/13 66/16 127/3 190/7 201/24 whatever [4] 23/23 30/14 151/2 174/18 when [99] 6/15 7/13 7/22 8/1 8/21 10/4 10/8 25/1 28/23 30/6 33/17 34/1 34/11 34/12 34/12 36/22 42/6 43/3 44/12 45/8 47/15 48/8 54/21 56/17 62/14 64/19 65/2 65/17 66/22 67/7 68/23 77/21 78/23 79/7 79/14 80/3 82/23 84/13 89/24 90/7 93/17 96/7 97/7 102/23 106/20 108/18 111/3 112/20 112/25 113/12 113/13 116/21 117/7 118/10 119/23 120/15 120/23 122/21 123/1 123/8 123/18 124/1 128/12 129/12 131/21 131/25 133/16 133/18 134/4 136/17 140/11 141/3 141/14 142/11 144/1 144/14 145/23 146/4 151/10 151/14 153/20 154/21 156/15 158/3 159/12 162/24 163/20 168/22 176/5 185/23 185/25 186/3 187/14 190/8 192/3 192/13 198/6 200/11 202/22	190/22 198/17 200/4 whereas [3] 6/14 25/14 29/23 whereby [1] 192/12 whether [38] 4/19 17/2 17/3 31/3 31/4 45/15 55/13 56/5 56/6 59/7 62/16 65/4 66/1 68/14 68/15 81/18 82/22 82/25 83/1 83/10 91/14 93/9 97/15 110/3 110/24 111/25 114/7 130/24 132/10 135/4 143/12 147/1 149/15 153/18 154/22 187/13 191/12 195/16 which [82] 1/15 1/21 2/19 7/23 8/15 10/16 12/18 16/14 22/7 26/20 28/13 31/5 32/2 32/15 35/13 38/11 39/4 39/14 41/10 43/18 43/20 44/7 52/9 57/10 61/5 63/20 67/15 79/5 83/20 86/4 87/2 93/1 93/17 95/23 105/9 105/15 105/22 108/16 111/14 113/8 116/8 124/11 127/15 128/14 131/5 132/17 135/19 137/3 138/13 142/10 149/15 156/10 156/11 157/7 158/17 162/22 166/8 166/13 169/9 170/6 176/13 182/21 185/14 187/5 187/23 188/15 189/25 191/24 192/1 192/1 192/25 196/6 196/19 197/3 198/5 198/25 200/22 202/2 202/6 203/5 203/10 204/6 whichever [2] 20/2 73/9 while [1] 73/6 whilst [8] 9/16 60/16 77/16 80/7 101/25 142/3 146/7 173/3 white [5] 25/16 45/24 100/9 182/24 183/8 Whitty [1] 178/17 who [108] 2/15 4/19 6/5 14/13 15/13 27/15 28/24 29/18 30/1 30/10 35/13 35/20 40/20 43/24 46/16 47/16 49/12 50/20 51/15 51/16 51/17 53/24 54/4 56/20 56/21 56/23 64/4 69/8 69/9 70/7 73/15 73/22 74/11 77/6 77/7 94/8 97/10 97/20 98/12	105/8 107/13 116/23 123/24 124/2 124/15 124/21 126/21 126/22 126/23 127/5 133/12 134/3 134/16 134/16 134/20 139/14 140/5 140/8 141/19 141/22 142/25 144/2 148/21 152/18 152/23 154/5 154/12 155/6 159/13 159/17 160/3 160/4 160/4 160/20 161/16 161/19 161/21 161/22 162/5 162/9 162/10 162/11 162/11 163/15 166/3 166/7 174/3 174/17 175/7 176/18 180/16 180/17 180/18 185/8 186/6 188/8 188/13 188/21 194/21 195/11 196/14 196/18 196/25 197/12 198/12 202/7 202/21 204/7 who'd [1] 188/21 who's [1] 197/7 whoever [2] 54/14 81/17 whole [19] 8/11 8/23 15/8 27/3 33/18 40/21 55/18 64/8 65/25 83/15 84/10 107/9 109/18 109/23 111/6 124/2 166/4 166/21 175/22 wholly [1] 52/5 whom [2] 185/7 186/19 whose [1] 203/2 why [67] 6/1 8/12 10/8 11/11 15/23 16/22 18/2 21/25 28/8 35/18 36/24 45/9 49/15 53/8 55/11 57/4 57/6 59/20 60/12 61/9 62/9 63/7 65/10 65/19 67/6 71/19 75/16 75/17 75/17 75/22 76/1 76/6 79/15 84/16 86/14 87/1 94/25 99/19 106/19 106/23 111/14 112/6 112/18 118/12 128/14 137/9 137/15 139/3 141/13 141/23 150/18 152/4 160/8 165/4 166/17 168/22 172/2 173/14 174/10 174/15 191/8 193/4 193/22 194/11 197/3 197/24 202/15 wide [2] 84/6 195/6 widely [1] 136/11 wider [17] 3/13 13/24 13/24 48/16 65/6 71/20 75/12 78/4
----------	--	--	---	---

W wider... [9] 99/21 100/1 100/22 101/12 102/3 103/13 117/22 141/14 170/24 wife [1] 24/9 will [30] 1/6 1/16 7/8 12/19 22/17 29/17 31/21 41/8 45/7 50/20 54/15 59/9 61/11 66/14 71/6 86/7 91/18 104/6 105/16 117/1 120/9 120/21 122/7 127/21 145/13 145/14 164/2 179/19 199/20 200/16 win [1] 194/11 windows [2] 70/22 193/1 winter [18] 5/13 5/14 5/15 5/18 10/6 73/7 145/9 145/9 145/16 145/22 152/14 153/19 169/18 170/9 172/9 173/24 174/14 203/13 wish [2] 116/4 118/18 wished [1] 177/8 wishes [2] 166/10 166/13 withdrew [2] 121/22 204/12 within [32] 7/24 27/12 64/7 71/3 75/12 75/13 81/9 89/14 97/11 113/11 123/23 136/23 138/3 140/6 140/9 141/5 147/22 149/7 150/17 154/12 156/1 159/5 159/6 164/22 165/20 179/5 190/25 192/21 195/3 196/10 200/8 201/16 within days [1] 89/14 without [11] 52/12 52/21 59/4 67/21 79/20 87/11 87/18 96/10 119/9 152/25 162/20 withstand [1] 154/1 Withybush [1] 120/24 witness [20] 1/4 110/21 121/22 124/11 126/8 135/2 138/11 140/11 146/17 154/19 155/13 162/17 164/4 164/15 169/4 174/5 176/10 193/7 204/6 204/12 woman [1] 81/19 women [11] 45/23 46/5 46/16 81/20	96/23 97/4 97/5 97/12 97/20 98/5 143/5 women's [1] 184/14 won't [6] 66/15 87/9 115/8 121/18 190/10 190/13 wonder [1] 167/8 wonderful [2] 7/13 182/10 words [6] 2/10 31/13 72/18 107/15 148/16 168/6 work [43] 9/22 15/13 22/15 22/17 33/25 35/24 42/8 47/1 49/7 50/19 56/9 60/15 74/14 84/3 94/3 94/4 94/10 98/11 100/3 101/25 102/7 102/19 103/2 114/17 121/4 130/11 130/15 133/25 137/17 145/14 156/1 156/6 156/18 160/2 160/22 173/22 174/3 174/22 175/12 175/23 179/9 182/1 182/2 worked [12] 12/23 26/16 37/4 46/22 52/4 90/5 91/10 128/13 159/5 161/9 179/25 181/19 worker [2] 53/18 134/2 workers [38] 43/16 43/19 43/21 45/18 46/8 46/9 46/16 55/14 55/22 56/4 58/2 58/8 58/11 62/24 78/13 78/14 78/19 78/25 93/23 102/14 112/16 114/12 132/23 142/22 142/24 142/25 173/13 173/16 175/3 175/19 177/16 177/22 177/25 178/12 178/15 178/18 178/22 182/3 workforce [8] 57/10 75/11 76/24 114/11 174/7 174/9 176/9 178/9 working [11] 40/11 94/3 115/4 123/22 134/14 134/16 149/11 150/15 150/18 190/25 191/13 workplace [5] 4/19 43/8 93/18 94/20 95/4 works [8] 7/13 10/24 100/22 109/18 117/13 120/15 193/4 193/6 world [5] 13/18 13/18 40/21 166/24 177/3 worried [5] 36/16 38/17 73/12 94/5	128/23 worry [3] 22/24 23/16 25/5 worrying [1] 39/18 worse [3] 10/6 18/8 138/17 worsened [4] 67/15 68/16 69/3 84/1 worsening [1] 68/12 worst [9] 18/12 18/20 18/24 20/2 22/13 22/14 22/25 31/19 39/9 worst-case [8] 18/12 18/20 18/24 20/2 22/13 22/14 22/25 31/19 worth [7] 6/4 13/6 63/4 93/6 128/11 147/14 153/23 would [147] 4/7 9/3 12/1 14/4 14/6 14/13 15/3 15/14 15/23 18/2 18/5 20/4 20/21 20/22 20/23 23/13 27/12 27/19 28/2 29/24 29/25 30/18 30/21 31/17 32/4 33/3 35/19 37/23 38/2 39/2 39/11 47/22 48/1 48/3 48/12 51/8 51/13 51/15 51/23 51/25 52/4 52/4 54/2 55/21 57/2 57/10 57/11 60/19 65/3 71/7 72/10 72/23 73/13 74/9 77/3 83/14 85/5 86/17 87/2 87/13 88/13 88/14 89/3 89/6 91/15 92/19 92/23 92/24 93/1 93/15 93/16 93/17 93/18 93/21 95/15 97/24 98/2 98/10 100/17 100/19 100/20 104/18 107/19 108/22 109/16 111/2 112/10 113/9 113/23 113/25 117/5 125/5 129/3 129/25 130/6 130/8 130/19 130/19 131/10 134/10 138/10 140/7 141/9 142/4 142/24 143/12 143/16 145/12 148/22 153/20 153/24 153/25 155/10 156/14 159/15 160/3 160/8 161/20 163/7 166/12 166/13 166/16 166/20 166/24 167/2 168/14 171/20 171/21 171/22 172/21 174/13 175/4 177/5 179/6 180/21 181/3 182/9 184/10 186/12 186/21 188/15 189/20	192/1 192/24 196/19 196/20 203/4 wouldn't [11] 5/2 8/24 28/10 29/20 65/14 89/5 95/9 110/19 136/25 163/25 202/18 wound [1] 61/25 Wrexham [3] 71/18 71/22 121/1 Wright [1] 118/25 write [1] 151/24 written [5] 80/14 162/21 164/5 164/8 193/15 wrong [3] 68/24 120/22 198/19 wrote [4] 80/20 151/6 153/9 153/15 Wyllie [1] 166/11 Y yeah [13] 29/6 39/2 58/9 68/17 84/5 128/11 134/15 138/5 172/15 178/23 184/8 188/25 196/1 year [5] 5/16 5/17 9/8 143/9 183/25 years [3] 1/19 9/15 203/15 yes [58] 7/20 11/5 18/15 18/17 19/4 23/24 24/24 26/3 32/19 32/22 33/25 34/7 38/4 38/18 39/4 39/8 42/23 44/4 44/10 45/21 45/25 47/25 48/4 49/6 49/6 51/3 58/11 58/16 68/9 71/5 71/18 75/9 78/18 80/11 89/16 89/22 90/3 90/16 92/6 92/23 92/23 93/13 93/19 95/7 99/3 113/22 131/21 135/7 178/23 190/6 192/15 192/21 193/18 193/19 195/5 196/2 196/16 197/3 Yesterday [1] 128/1 yet [2] 17/25 92/20 yn [4] 121/11 121/21 204/1 204/11 you [950] you know [54] 4/6 14/15 18/7 21/12 22/4 22/24 29/6 30/20 30/21 33/14 37/15 40/19 44/18 46/8 61/20 73/4 74/2 74/14 79/17 89/8 115/16 117/20 118/15 129/5 133/11 134/3 140/21 142/2 145/2 147/12	147/23 150/9 150/14 154/16 158/5 158/6 160/3 160/6 160/25 167/1 167/4 173/19 174/21 174/25 179/22 180/1 181/1 181/23 184/18 184/22 192/5 194/13 200/16 202/12 you want [1] 10/24 you'd [15] 8/20 11/22 15/8 15/9 28/6 56/11 85/7 86/15 87/4 93/21 98/2 160/9 167/5 167/23 177/3 you'll [4] 3/5 18/7 57/13 119/18 you're [53] 10/8 10/9 11/3 12/9 20/3 21/11 23/18 26/12 28/15 28/24 32/15 33/17 35/10 35/11 38/15 48/5 52/2 55/9 56/14 57/5 61/21 82/1 82/18 82/22 85/16 93/10 97/25 100/1 100/3 100/7 104/14 106/11 111/14 111/23 127/1 129/13 129/15 130/2 130/4 130/7 130/21 133/11 161/7 164/16 165/25 177/19 177/20 179/17 180/20 181/22 182/14 191/20 194/12 you've [47] 20/24 21/18 23/24 37/15 37/20 38/14 44/7 49/3 53/21 55/18 55/23 56/3 66/7 66/8 66/11 66/24 70/13 78/25 83/18 88/20 90/20 101/14 103/12 107/4 112/22 115/14 115/19 118/24 119/12 119/15 127/18 138/11 139/22 140/11 141/5 154/19 155/13 155/17 156/8 157/8 158/7 159/19 160/2 164/4 186/14 186/21 200/7 younger [1] 155/7 your [139] 1/15 2/1 2/2 2/4 2/10 2/13 2/23 3/15 12/15 12/24 13/11 13/11 13/14 14/20 15/19 16/4 16/7 16/7 19/1 19/17 20/10 20/10 20/14 21/18 22/14 22/16 23/11 23/11 24/13 24/16 25/18 25/21 28/25 29/1 31/11 31/13 33/23 34/3 36/6 36/10 38/5 41/11 42/24 43/15 44/2 47/3 47/6
---	--	--	--	--

Y

your... [92] 47/23
48/19 49/1 49/3 50/23
50/24 53/10 58/2
58/16 59/18 61/22
61/22 69/12 71/16
72/18 76/3 79/1 81/7
81/18 83/12 83/21
84/2 85/5 85/6 85/8
85/11 86/11 86/20
88/9 89/22 96/8 99/6
103/20 109/3 110/21
112/14 121/20 122/7
122/8 122/11 123/7
123/7 123/23 124/5
124/7 124/9 124/11
124/17 125/3 126/8
126/9 134/10 135/2
135/5 138/11 140/11
141/5 144/12 146/17
151/12 154/19 154/24
154/25 155/13 157/8
162/17 164/4 164/8
164/15 167/16 168/6
169/4 174/5 176/10
177/22 180/10 182/22
183/16 183/24 185/12
185/16 189/19 193/7
193/12 195/23 200/1
200/1 201/9 201/16
201/20 201/22 204/10

yourself [6] 5/24 50/3
57/12 67/7 152/17
201/21

YouTube [1] 7/6

Z

zone [2] 12/11 12/14